

13859

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>Columbia</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>D.C. Washington 47x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>25 Longfellow St, NW.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jane</u> Middle <u>Elizabeth</u> Last <u>Abbott</u>				4. DATE OF DEATH Month <u>12</u> - Day <u>17</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-21-13</u>		9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Brown</u>			14. MOTHER'S MAIDEN NAME <u>Mary B. Phillips</u> FILLIUS				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Hospital Records</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Malignant lymphoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> to <u>Dec. 17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/16</u> , 19 <u>58</u> , and that death occurred at <u>1:45 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel M. Bageant</u> M.D.				ADDRESS (Street, city or town, state) <u>5600 N.H. Ave. Wash. D.C.</u> DATE SIGNED <u>12/17/58</u>			
PHYSICIAN'S NAME (Type) <u>SAMUEL M. BAGEANT</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>DEC 19 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13898

CERTIFICATE OF DEATH

13848

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montg</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington Grove.</u>	c. LENGTH OF STAY IN 1b <u>45 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Washington Grove</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Leo</u> <u>H</u> <u>Achenbach</u>		4. DATE OF DEATH Month <u>Dec</u> <u>23</u> Day <u>19</u> Year <u>58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1st 1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Florest</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penn.</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William Achenbach</u>		14. MOTHER'S MAIDEN NAME <u>Annie V. Harrar</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>0</u>	
17. INFORMANT <u>Mrs Joseph M. Ramson</u>		Address <u>San Antonio Texas.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure.</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis.</u> DUE TO (c) <u>Generalized Arteriosclerosis.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1956</u> , 19 <u>58</u> , to <u>12/23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/22</u> , 19 <u>58</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lucius L. Lead</u>		ADDRESS (Street, city or town, state) <u>Gaithersburg Md.</u>	
PHYSICIAN'S NAME (Type) <u>Lucius L. Lead</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-27-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	22d. LOCATION (City, town, or county) (State) <u>Gaithersburg Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner. Gaithersburg. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 29 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13899

CERTIFICATE OF DEATH

Reg. Dist. No.

13849

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ROCKVILLE				c. LENGTH OF STAY IN 1b 3 1/2 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WAVERLY SANITARIUM				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LULU M. AILES				4. DATE OF DEATH Month DECEMBER Day 6 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 28, 1874	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER, retired		10b. KIND OF BUSINESS OR INDUSTRY OHIO	
11. BIRTHPLACE (State or foreign country) U. S. A.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME HEZEKIAH S. AILES				14. MOTHER'S MAIDEN NAME JANE ELLIOTT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address MD. CHARLES C. AILES, 8617 LANCASTER DR., BETHESDA.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia (terminal) 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral Thrombosis DUE TO (c) 3 yrs				INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1-15 , 19 50 , to 12-6 , 19 58 , that I last saw the deceased alive on 12-4 , 19 58 , and that death occurred at 3:25 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Hill Carter				ADDRESS (Street, city or town, state) 1835 Eye St NW Washington DC			
PHYSICIAN'S NAME (Type) HILL CARTER				DATE SIGNED 12-6-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF DEC. 8, 1958		22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE'S CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond C. Ziska				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE DEC 10 '58	
				24b. REGISTRAR'S SIGNATURE Arthur E. K...			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13900

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13850

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dawsonville</u>		c. LENGTH OF STAY IN 1b <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dawsonville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Poolesville R.F.D.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
3. NAME OF DECEASED (Type or print) <u>Edwin Ruthvin Allmatt</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>28</u> Year <u>1958</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-26-1892</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u> Owner				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
13. FATHER'S NAME <u>Edwin Allmatt</u>				14. MOTHER'S MAIDEN NAME <u>Anne Chiswell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Carrie Allmatt (wife)</u> <u>Item 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/31/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		22d. LOCATION (City, town, or county) (State) <u>Beallsville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton</u>				ADDRESS <u>Barnesville, Md</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>JAN 2 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Krens</u>			

2

13902 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				4. DATE OF DEATH Month <i>Dec.</i> Day <i>17</i> Year <i>1958</i>			
3. NAME OF DECEASED (Type or print) <i>(newborn) Baby Boy Anderson</i>				5. SEX <i>male</i> 6. COLOR OR RACE <i>white</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <i>12/16/58</i>			
9. AGE (In years lost birthday) yrs. <i>10</i> 10. IF UNDER 1 YEAR Months <i>10</i> Days <i>4</i> 11. IF UNDER 24 HRS. Hours <i>10</i> Min. <i>41</i>				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>—</i> 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Russel Anderson</i>				14. MOTHER'S MAIDEN NAME <i>Peggy Louise Pritchard</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service) <i>—</i>				16. SOCIAL SECURITY NO. <i>—</i> 17. INFORMANT <i>Peggy Louise Pritchard</i> Address <i>Route #3 Gaithersburg, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anoxia</i> <i>762.5</i> DUE TO <i>Pulmonary Stenosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>—</i> DUE TO <i>Prematurity</i> (c) <i>—</i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Twinning</i>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>12-16</i> , 19 <i>58</i> to <i>12-17</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>12-17</i> , 19 <i>58</i> , and that death occurred at <i>6:30 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Paul deLantor</i>				ADDRESS (Street, city or town, state) <i>4709 Montgomery Lane Bethesda</i>			
PHYSICIAN'S NAME (Type) <i>—</i>				DATE SIGNED <i>DEC 22 '58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-18-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Forest Oak Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Gaithersburg, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>—</i> ADDRESS <i>316 E Diamond Ave Gaithersburg, Md.</i>				24a. REC'D BY REGISTRAR <i>—</i> DATE <i>DEC 22 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraw</i>	

2274191XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 and be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13901

CERTIFICATE OF DEATH

13851

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 20½ hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Gaithersburg	
		d. STREET ADDRESS Route #3	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (Newborn) Baby Girl		4. DATE OF DEATH Month December Day 17 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/16/58
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days 20 yrs 29	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Russel Anderson		14. MOTHER'S MAIDEN NAME Peggy Louise Pritchard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT Peggy Louise Pritchard	
		Address Route 3 Gaithersburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-16 , 19 58 , to 12-17 , 19 58 , that I last saw the deceased alive on 12-17 , 19 58 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Paul D Cantor M.D. 4709 Montgomery Lane PHYSICIAN'S NAME (Type) Bethesda			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/58	
22c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery		22d. LOCATION (City, town, or county) (State) Gaithersburg Md	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Hanna		24a. REC'D BY REGISTRAR DATE DEC 22 '58	
ADDRESS 316 E Diamond Ave, Gaithersburg, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

2174191XVI

13903

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 16 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Macker Middle (none) Last BABB				4. DATE OF DEATH Month December Day 12 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-18-70	9. AGE (In years last birthday) 88	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine Corps Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Marine Corps.		11. BIRTHPLACE (State or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William J. BABB				14. MOTHER'S MAIDEN NAME Mary E. Arnold			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes SpAm - WWI		16. SOCIAL SECURITY NO. None		17. INFORMANT OFFICIAL NAVY RECORDS			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 26, 1958 , to December 12, 1958 , that I last saw the deceased alive on December 12, 1958 , and that death occurred at 9:20A M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. T. Horgan		M.D. U. S. Naval Hospital		DATE SIGNED 12-12-58			
PHYSICIAN'S NAME (Type) J. T. HORGAN, LCDR, MC, USN		Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-16-58	22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				24a. REC'D BY REGISTRAR DEC 17 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	
23. FUNERAL HOME R. A. Pumphrey Funeral Home, Bethesda, Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

Name of Deceased (Print Name)		Sex (M or F)		Date of Birth	
Place of Birth		Usual Residence		Date of Death	
Cause of Death (Specify)		Duration of Illness		Place of Death	
Name of Physician		Name of Undertaker		Name of Burial Place	
Name of Registrar		Signature of Registrar		Date of Registration	

13904

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>1708 Corwin Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>B</u> Last <u>Bair</u>		4. DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 31, 1901</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>3</u> Hours <u>3</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate Broker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH BENJAMIN BAIR</u>		14. MOTHER'S MAIDEN NAME <u>CAROLINE FENTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-07-1569</u>	
17. INFORMANT <u>Martha L Blair Wife</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebellar Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 hr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>58</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Dec 1</u> , 19 <u>49</u> , to <u>Dec 31</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 31</u> , 19 <u>58</u> , and that death occurred at <u>7:35 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Merrill M. Cross</u> M.D.		ADDRESS (Street, city or town, state) <u>8748 Georgia Ave. SILVER SPRING, MARYLAND</u>	
DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Krasa</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Day No.

PLACE OF BIRTH COUNTY STATE		PLACE OF DEATH COUNTY STATE	
DATE OF BIRTH DAY MONTH YEAR		DATE OF DEATH DAY MONTH YEAR	
SEX MALE FEMALE		RACE WHITE NEGRO	
OCCUPATION TRADE, PROFESSION, SERVICE, OR Vocation		CAUSE OF DEATH 1. Immediate Cause 2. Intermediate Cause 3. Remote Cause	
PLACE OF DEATH HOME HOSPITAL OTHER		SIGNATURE OF DECEASED DATE	
SIGNATURE OF WITNESS DATE		SIGNATURE OF PHYSICIAN DATE	
SIGNATURE OF CLERK DATE		SIGNATURE OF REGISTRAR DATE	

This certificate is to be filled out by the physician or other person who has attended the deceased, or by the registrar if the deceased was not attended by a physician. It should be filled out as soon as possible after death, and should be filed in the office of the registrar of the county in which the death occurred. The certificate should be filled out in duplicate, one copy to be filed in the office of the registrar, and the other copy to be sent to the office of the health officer of the city or town in which the death occurred.

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TO HOSPITAL OR OFFENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13905 CERTIFICATE OF DEATH

Reg. Dist. No. 215

13855

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lincoln Middle (n) Last BALL				4. DATE OF DEATH Month December Day 18 Year 1958			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-28-19	
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months 18 Days 19 Hours 58 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Clerk		11. BIRTHPLACE (State or foreign country) W. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Osburne BALL		14. MOTHER'S MAIDEN NAME Bell LEWIS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WWII	
16. SOCIAL SECURITY NO. 233-26-0906		17. INFORMANT (W) Mrs. Virginia W. Ball, same as #2 above		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cor pulmonale DUE TO (c) Chronic bronchiectasis		INTERVAL BETWEEN ONSET AND DEATH 2-3 hours 5-10 yrs 5-10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from December 16, 1958 , to December 18, 1958 , that I last saw the deceased alive on December 18, 1958 , and that death occurred at 9:15 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Jerome A. Gold				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNM DATE SIGNED 12-18-58			
PHYSICIAN'S NAME (Type) Jerome A. GOLD, LT, MC, USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-22-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) (State) Arlington Virginia				24a. REC'D BY REGISTRAR DEC 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers, 3072 "M" St., NW, Washington, DC							

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
1905
CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John J. Smith		Male		45	
Residence		Occupation		Cause of Death	
1234 Main St., Baltimore, Md.		Carpenter		Heart Disease	
Date of Death		Time of Death		Place of Death	
Jan 15, 1905		10:30 AM		Home	
Physician		Burial Place		Interment	
Dr. J. H. Jones		St. Mary's Cemetery		Buried	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1390 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13856

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b DOA			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital			d. STREET ADDRESS 2800 Quebec St., N.W.		
3. NAME OF DECEASED (Type or print) Effie McCumber BARNES			4. DATE OF DEATH Month December Day 8 Year 19 58		
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-9-70	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY - - -		
11. BIRTHPLACE (State or foreign country) Minn.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Robert B. MC CUMBER			14. MOTHER'S MAIDEN NAME Anna FULLER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		
17. INFORMANT Son, Robert McC. Barnes, same as #2 above			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Found dead in bed at home
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Suitland	(County) Md.	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-8-58	
EXAMINER'S NAME (Type) Frank Broschart, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12-9-58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
22d. LOCATION (City, town, or county) Suitland		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		ADDRESS Pumphrey Funeral Home, Bethesda, Md.		24a. REC'D BY REGISTRAR DEC 10 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

13860 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK			c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL				d. STREET ADDRESS 10,324 PARKMAN ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRIS Middle WHIPPLE Last BARNUM				4. DATE OF DEATH Month DEC. Day 31 Year 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/19/90	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ANALYST (Bureau of Budget) U. S. Gov't.				10b. KIND OF BUSINESS OR INDUSTRY VERMONT		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ZALMAN BARNUM				14. MOTHER'S MAIDEN NAME ELEANOR unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Helen A. Barnum, 10324 Parkman Rd. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart Disease							INTERVAL BETWEEN ONSET AND DEATH 5 1/2 days Unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1948 , 19____, to Dec 31 , 19 58 , that I last saw the deceased alive on Dec 30 , 19 58 , and that death occurred at 7:00 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Aaron H. Traum				ADDRESS (Street, city or town, state) 8237 Georgia Ave Silver Spring, Md DATE SIGNED 12/31/58			
PHYSICIAN'S NAME (Type) AARON TRAUM							
22a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT		22b. DATE THEREOF 1/3/59		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN MAUSOLEUM		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Kinn	
				24c. REC'D BY REGISTRAR DATE JAN 2 '59			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4. may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13861 CERTIFICATE OF DEATH

Reg. Dist. No. 13858

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>75 Washington Sanitarium Hosp. Tk. Pk. Md.</u>				d. STREET ADDRESS <u>56 Silver Spring</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Connor</u> Middle <u>Burket</u> Last <u>Batman</u>				4. DATE OF DEATH Month <u>December</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-22-00</u>	9. AGE (In years lost birthday) <u>58</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Small business Representative for Gov't. administration</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>But Joseph B. Batman</u>				14. MOTHER'S MAIDEN NAME <u>Frances Kibler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWI</u>				16. SOCIAL SECURITY NO. <u>yes</u>			
17. INFORMANT Address <u>Mrs. Beryl F. Batman, 609 Bonifant St. Silver Spring, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, metastatic</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov 22, 1958</u> , to <u>Dec 22, 1958</u> , that I last saw the deceased alive on <u>Dec 22, 1958</u> , and that death occurred at <u>1:40 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. F. Thibadeau</u>				DATE SIGNED <u>12/22/58</u>			
PHYSICIAN'S NAME (Type) <u>A. F. THIBADEAU</u>				ADDRESS (Street, city or town, state) <u>10111 Colasville Rd. Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beahm's Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Luray, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY INC</u>				24a. REC'D BY REGISTRAR <u>Raymond A. Ziska</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. This is a true and correct copy of the original as shown to me by the person who presented it for filing.
2. I am a duly qualified and sworn medical examiner.
3. I have examined the body of the deceased and have found that the death was caused by the disease or injury stated on the certificate.
4. I have examined the certificate and find it to be a true and correct copy of the original as shown to me by the person who presented it for filing.
5. I have examined the certificate and find it to be a true and correct copy of the original as shown to me by the person who presented it for filing.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF MEDICAL EXAMINER		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF CLERK	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS		21. SIGNATURE OF WITNESS	
22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
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1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13907 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13859

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville (rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rockville (rural)</u>	
c. LENGTH OF STAY IN 1b <u>6 mo.</u>		d. STREET ADDRESS <u>River Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>River Rd. R-1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Florence G. Beaupre</u>		4. DATE OF DEATH <u>12-25-</u> 19 <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9, 1904(?)</u>
9. AGE (In years and birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR <u>2</u> Months <u>16</u> Days	
11. IF UNDER 24 HRS. <u>11</u> Hours <u>11</u> Min.		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
13. FATHER'S NAME <u>Fred Perrotte</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Facteau (LILIAN FACTEAU)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-48-7196</u>	
17. INFORMANT <u>Daughter</u>		Address <u>Mrs. Robert A. Walde, Pittsburgh, Penna.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in bed</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-30-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawler's Sons</u> ADDRESS <u>Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>DEC 30 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13908 CERTIFICATE OF DEATH

13860

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 9 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 111 MELBOURNE AVENUE		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 111 MELBOURNE AVENUE		d. STREET ADDRESS 111 MELBOURNE AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle CHRISTOPHER Last BECK		4. DATE OF DEATH Month DEC. Day 17 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 25, 1881
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Christopher Beck		14. MOTHER'S MAIDEN NAME Sophia Kuntz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 183-01-9395	
17. INFORMANT Mrs. Margaret B. Brown, 111 Melbourne Ave. Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Prostate DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 177X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia INTERVAL BETWEEN ONSET AND DEATH 4 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 , 19____, to Dec 17 , 19 58 , that I last saw the deceased alive on Dec 17 , 19 58 , and that death occurred at 1 P. M, from the causes and on the date stated above. ACTUAL SIGNATURE John N. Andrews ADDRESS 9601 Colesville Rd Silver Spring DATE SIGNED 12/17/58 PHYSICIAN'S NAME (Type) JOHN N. ANDREWS			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF 12/20/58	22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY	22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		24a. REC'D BY REGISTRAR DATE DEC 22 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kuntz

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12208 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED [Name]		2. SEX [Male/Female]		3. AGE [Age]	
4. DATE OF DEATH [Date]		5. TIME OF DEATH [Time]		6. PLACE OF DEATH [Place]	
7. CAUSE OF DEATH [Cause]		8. MANNER OF DEATH [Manner]		9. SIGNATURE OF REGISTRAR [Signature]	
10. SIGNATURE OF DECEASED [Signature]		11. SIGNATURE OF WITNESS [Signature]		12. SIGNATURE OF PHYSICIAN [Signature]	
13. SIGNATURE OF FUNERAL HOME [Signature]		14. SIGNATURE OF BURIAL PLACE [Signature]		15. SIGNATURE OF INTERVIEWER [Signature]	
16. SIGNATURE OF CORONER [Signature]		17. SIGNATURE OF JURY [Signature]		18. SIGNATURE OF JUDGE [Signature]	
19. SIGNATURE OF PROSECUTOR [Signature]		20. SIGNATURE OF DEFENSE [Signature]		21. SIGNATURE OF JURY [Signature]	
22. SIGNATURE OF JUDGE [Signature]		23. SIGNATURE OF JURY [Signature]		24. SIGNATURE OF JURY [Signature]	
25. SIGNATURE OF JURY [Signature]		26. SIGNATURE OF JURY [Signature]		27. SIGNATURE OF JURY [Signature]	
28. SIGNATURE OF JURY [Signature]		29. SIGNATURE OF JURY [Signature]		30. SIGNATURE OF JURY [Signature]	
31. SIGNATURE OF JURY [Signature]		32. SIGNATURE OF JURY [Signature]		33. SIGNATURE OF JURY [Signature]	
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97. SIGNATURE OF JURY [Signature]		98. SIGNATURE OF JURY [Signature]		99. SIGNATURE OF JURY [Signature]	
100. SIGNATURE OF JURY [Signature]		101. SIGNATURE OF JURY [Signature]		102. SIGNATURE OF JURY [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13909 CERTIFICATE OF DEATH

13861

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colesville		c. LENGTH OF STAY IN 1b 8 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marilea Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
4. DATE OF DEATH Dec 8 1958		d. STREET ADDRESS 1760 Euclid St. NW # 502	
3. NAME OF DECEASED (Type or print) Minerva Griswold First Middle Last		4. DATE OF DEATH Dec 8 1958	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 23, 1872	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Dept. Agricult. Michigan	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William G. Beckwith		14. MOTHER'S MAIDEN NAME Maria Gibson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Mr. Geo. Flather, Jr. Colorado Bldg. DC		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 350x Parkinson's Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Terminal Arteriosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-16 , 19 58 , to 12-8 , 19 58 , that I last saw the deceased alive on 11-30 , 19 58 , and that death occurred at 2:20 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE John S. Rogers M.D.		ADDRESS (Street, city or town, state) 1919 Seminary Road DATE SIGNED 12-8-58	
PHYSICIAN'S NAME (Type) John S. Rogers			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/12/58	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Grand Rapids Michigan	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph G. G. G. G.		ADDRESS 1756 Pa. Ave DC	
24a. REC'D BY REGISTRAR DEC 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. H. H.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13910 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13862

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b X Bethesda		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4500 Harling Lane			e. STREET ADDRESS 4500 Harling Lane		
3. NAME OF DECEASED (Type or print) JOHN P. BELLEW			4. DATE OF DEATH Month December Day 15 Year 19 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1889		9. AGE (In years last birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Textile worker	11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME Patrick Bellew			14. MOTHER'S MAIDEN NAME Margaret Hall		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 029-03-2046	17. INFORMANT Margaret Bellew-wife-item 2d		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		12/15/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-18-58	22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland			24a. REC'D BY REGISTRAR DATE DEC 18 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13-02

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
RESIDENCE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13863

13911

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia				b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 681 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beckley				85X-3 ✓							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 214 Jennings Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Henry Benedict				4. DATE OF DEATH Month Day Year December 1, 19 58															
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 7, 1915		9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mining Engineer				10b. KIND OF BUSINESS OR INDUSTRY Mining				11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Benedict				14. MOTHER'S MAIDEN NAME Anna (unknown)															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 403-18-4470				17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 193.3 ? Gram Negative Septicemia DUE TO Lumbo Sacral Chondro sarcoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from January 19, 1957 , to December 1, 1958 , that I last saw the deceased alive on December 1, 1958 , and that death occurred at 3:10p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 12/2/58 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland																			
ACTUAL SIGNATURE James A. Rose				M.D. JAMES A. ROSE, M.D.															
PHYSICIAN'S NAME (Type)																			
22a. BURIAL, CREMATION, REMOVAL, TRANSIT Burial Transit				22b. DATE THEREOF 12/2/58				22c. NAME OF CEMETERY OR CREMATORY Sunset				22d. LOCATION (City, town, or county) (State) Beckley, W. Virginia							
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland								ADDRESS				24a. REC'D BY REGISTRAR DATE DEC 5 '58				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13912

CERTIFICATE OF DEATH

13864

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DC b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Benjamin Middle Benow Last		4. DATE OF DEATH Month Dec Day 16 Year 1958	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 24, 1883
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK NEWS STAND		11. BIRTHPLACE (State or foreign country) ROMANIA	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNK. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 144-03-9507A	
17. INFORMANT MR. MICHAEL KORN		Address 1400 GUYARD ST. PHILA. PA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coagulative Heart Failure 420.0 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary DUE TO Arteriosclerotic Heart Disease (c)			INTERVAL BETWEEN ONSET AND DEATH 8 Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 12 58 to Dec 16 58 , that I last saw the deceased alive on Dec 16 58 , and that death occurred at 12:10 p. m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert T. Thibadeau M.D.		ADDRESS (Street, city or town, state) 10609 Concord St. Kensington, Md.	
DATE SIGNED Dec 16, 1958			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12/19/58	22c. NAME OF CEMETERY OR CREMATORY HAR SHUDAN Cem	22d. LOCATION (City, town, or county) (State) Phila. Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Real Funeral Home ADDRESS 4812 92nd St. N.E.		24a. REC'D BY REGISTRAR DEC 22 58 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thoma	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13865

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY _____					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>248 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>1814 35th Street, N. W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Henry Alexander Berry</u>				4. DATE OF DEATH Month Day Year <u>December 20, 1958</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 25, 1903</u>			
				9. AGE (In years last birthday) yrs. <u>55</u>		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Henry A. Berry</u>				14. MOTHER'S MAIDEN NAME <u>Clara Tyler</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW II</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Obstruction of Respiratory Tree with Mucous</u> <u>237x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Brain Tumor, Right Fronto-Parietal</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Obstructive Pulmonary Emphysema</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 Year</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <u>April 16, 1958</u> to <u>December 20, 1958</u> , that I lost saw the deceased alive on <u>December 20, 1958</u> , and that death occurred at <u>7:10 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>12-21-58</u> ACTUAL SIGNATURE <u>William R. Lewis</u> M.D. <u>National Institutes of Health</u> PHYSICIAN'S NAME (Type) <u>William R. Lewis, M. D.</u> <u>Bethesda 14, Maryland</u>									
22a. DATE OF CREMATION, REMOVAL (Specify) <u>12/22/1958</u>		22b. DATE THEREOF <u>12/22/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Prin. Geos. Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Howard</u>				ADDRESS <u>56 Pa. Ave NW, DC</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 23 '58</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>					

VS A15 (4)
15M 10/57

VS A15 (4)
15M 10/57

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13914 CERTIFICATE OF DEATH

13866

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hillcrest Sanitarium		d. STREET ADDRESS #3 Pooks Hill Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MADISON Middle J Last BISBEE		4. DATE OF DEATH Month Dec. Day 26 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1874
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 8 Days 17 Hours 17 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Customs Office	
11. BIRTHPLACE (State or foreign country) Vermont		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John Bisbee		14. MOTHER'S MAIDEN NAME Susan Perkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. George Abbott-daughter-same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia, lobar, bilat. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) C.V.A., right hemiplegia DUE TO (c) arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 490X diabetes mellitus			
INTERVAL BETWEEN ONSET AND DEATH 1 days 14 days Over 10 yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 Aug. , 19 57 , to 25 Dec. , 19 58 , that I last saw the deceased alive on 25 Dec. , 19 58 , and that death occurred at 12:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7659 Old Georgetown Rd., Bethesda, Md. DATE SIGNED 26 Dec 58			
ACTUAL SIGNATURE John M. Wyman		M.D. John M. Wyman, M. D.	
PHYSICIAN'S NAME (Type)		7659 Old Georgetown Rd., Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		22b. DATE THEREOF 12/27/58	
22c. NAME OF CEMETERY OR CREMATORY Pine Grove		22d. LOCATION (City, town, or county) (State) Newport, Vermont	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DEC 30 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13867

13862 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASHINGTON, D.C.</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOKOMA PARK</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>OAK HAVEN REST HOME</u>		d. STREET ADDRESS <u>5601-13th ST. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle <u>LEONA</u> Last <u>BISHOP</u>		4. DATE OF DEATH Month <u>12</u> Day <u>-15</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 3, 1894</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SIMON PRICHARD</u>		14. MOTHER'S MAIDEN NAME <u>LUCY KEISTER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>W.N. BISHOP</u>		Address <u>5601-13th ST. N.W. (D.C.)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage, Pulmonary</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X DIABETES MELLITUS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> , 19 <u> </u> , to <u>12/15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/15</u> , 19 <u>58</u> , and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel A. Hillman</u> M.D.		ADDRESS (Street, city or town, state) <u>249 Massachusetts Ave NW</u> DATE SIGNED <u>12/15/58</u>	
PHYSICIAN'S NAME (Type) <u>SAMUEL A. HILLMAN</u>		<u>Washington 11 DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/17/58</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. DEAL</u>		ADDRESS <u>4812 GA. AVE N.W.</u>	
24a. REC'D BY REGISTRAR <u>DEC 19 '58</u>		24b. REGISTRAR'S SIGNATURE <u>John S. Kiana</u>	

13915 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Bethesda, Md b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			c. LENGTH OF STAY IN 1b 6 Mo. 21 Ds.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium			d. STREET ADDRESS 8203 Woodhaven Blvd.		
3. NAME OF DECEASED (Type or print) First Susan Middle Bailey Last Blake			4. DATE OF DEATH Month Dec Day 24 Year 19 58		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-6-1880		9. AGE (In years last birthday) 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressmaker - Self-employed			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME John Richard Bailey		
14. MOTHER'S MAIDEN NAME Adelaide Louella unknown			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Weldon B. Benson, 8203 Woodhaven Blvd.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, lungs, metastatic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, breast, it DUE TO (c) Bethesda, Maryland ONSET AND DEATH 3 yrs. 6 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			20g. (City or town) (County) (State)		
21. I certify that I attended the deceased from Jan. 19 58 to Dec. 24, 19 58 , that I last saw the deceased alive on Dec. 23, 19 58 , and that death occurred at 8:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10,602 Ga. Ave., Silver Spring, Md DATE SIGNED 12/24/58					
ACTUAL SIGNATURE Philip H. Varner M.D.			22. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		
PHYSICIAN'S NAME (Type) Philip H. Varner			22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		
22b. DATE THEREOF 12/26/58			22c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		
22d. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska			22e. ADDRESS SILVER SPRING, MD.		
22f. REC'D BY REGISTRAR DEC 29 1958			22g. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13916 CERTIFICATE OF DEATH

13869

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>36 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>6412 Ruffin Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Block</u> Last <u>Block</u>				4. DATE OF DEATH Month <u>December</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/7/98</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Illinois</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Walker</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Merlyn J. Block</u>				Address <u>6412 Ruffin Road Chevy Chase, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>years</u> <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u> </u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>10:05 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4890 Battery Lane</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Charles Savarese</u> M.D. <u> </u>				PHYSICIAN'S NAME (Type) <u>CHARLES SAVARESE</u> <u>Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 2, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u> </u>		22d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danyanaky & Sons 3501-14th St</u>				24a. REC'D BY REGISTRAR <u>DEC 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knead</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13917 CERTIFICATE OF DEATH

Reg. Dist. No.

13870

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Prince George</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>		c. LENGTH OF STAY IN 1b <i>1 month</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i> <i>1641.2</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove foundation</i>				d. STREET ADDRESS <i>Box 396</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>William O Bounds</i>				4. DATE OF DEATH Month Day Year <i>December 27 1958</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Cauc</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June 9 1873</i>	
9. AGE (In years last birthday) <i>85</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Corn farm</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Dennis Bounds</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Robey</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Paul E Bounds 1300 Brooklyn Bridge</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho-Pneumonia Viral</i> <i>491X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Smility</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>12/11</i> , 19 <i>58</i> , to <i>12/27</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>12/29</i> , 19 <i>58</i> , and that death occurred at <i>4:55 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>J. M. BIRD</i>				ADDRESS (Street, city or town, state) DATE SIGNED <i>Laurel Md</i> <i>12/27/58</i>			
PHYSICIAN'S NAME (Type) <i>J. M. BIRD</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>12/29/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Union Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Burtonsville Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>DeWitt Canabson</i>				ADDRESS <i>Laurel Md</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Huns</i>	
24a. REC'D BY REGISTRAR DATE <i>DEC 31 '58</i>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF DECEASED		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CORONER		16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK		19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF OFFICIAL	
JAMES M. SMITH		Male		45		White		1900		Baltimore, Md.		1945		Baltimore, Md.		10:00 AM		Heart Disease		Natural																			
1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF DECEASED		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CORONER		16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK		19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF OFFICIAL	
JAMES M. SMITH		Male		45		White		1900		Baltimore, Md.		1945		Baltimore, Md.		10:00 AM		Heart Disease		Natural																			

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13918

CERTIFICATE OF DEATH

13871

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 50 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Warren c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Front Royal d. STREET ADDRESS Box 585 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Oscar Middle Ludwell Last Bowen		4. DATE OF DEATH Month December Day 11 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 1, 1883
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Law	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edwin Thornton Bowen		14. MOTHER'S MAIDEN NAME Nancy Tanner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Disseminated Histoplasmosis DUE TO Adrenal necrosis secondary to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia DUE TO (c) Pulmonary Edema PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Edema			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 22, 1958 to December 11, 1958 , that I last saw the deceased alive on December 11, 1958 , and that death occurred at 7:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Albert Treger, M.D. M.D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12-11-58	
PHYSICIAN'S NAME (Type) Albert Treger, M. D.		The National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) 12/13/58		22b. DATE THEREOF 12/13/58	
22c. NAME OF CEMETERY OR CREMATORY La Crosse Cemetery		22d. LOCATION (City, town, or county) (State) La Crosse Va	
23. FUNERAL DIRECTOR'S SIGNATURE Cherry Chumford ADDRESS 5105 State		24. REC'D BY REGISTRAR DEC 15 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

18-118

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore 18

<p>NAME OF DECEASED J. J. JONES</p>		<p>AGE 50 years</p>		<p>SEX Male</p>	
<p>DATE OF DEATH December 11, 1918</p>		<p>PLACE OF DEATH The Medical Center, Baltimore, Md.</p>		<p>Cause of Death Influenza</p>	
<p>RESIDENCE Baltimore, Md.</p>		<p>EDUCATION High School</p>		<p>OCCUPATION Clerk</p>	
<p>DATE OF BIRTH January 1, 1868</p>		<p>PLACE OF BIRTH Maryland</p>		<p>RELIGION Roman Catholic</p>	
<p>NAME OF PHYSICIAN Dr. J. J. Jones</p>		<p>NAME OF FUNERAL HOME The National Funeral Home</p>		<p>NAME OF BURIAL PLACE St. Mary's Cemetery</p>	
<p>NAME OF NEXT OF KIN Mrs. J. J. Jones</p>		<p>NAME OF WITNESS Dr. J. J. Jones</p>		<p>NAME OF REGISTRAR J. J. Jones</p>	
<p>NAME OF CLERK J. J. Jones</p>		<p>NAME OF ASSISTANT CLERK J. J. Jones</p>		<p>NAME OF CHIEF CLERK J. J. Jones</p>	

13919 CERTIFICATE OF DEATH

13872

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>8 Months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Althea Glenn Nursing Home</u>		d. STREET ADDRESS <u>19709 Sutherland Road</u>	
3. NAME OF DECEASED (Type or print) <u>Lin</u> <u>Hutchinson</u> <u>Boyer</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 24, 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>David Michael Boyer</u>	
14. MOTHER'S MAIDEN NAME <u>Leah Hutchinson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Edward Boyer 9701 Sutherland Rd. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate with generalized</u> <u>metastasis.</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>24 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month _____ Day _____ Year <u>1958</u> Hour o. m. _____ p. m. _____	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>HYATTSVILLE, MD</u>		(County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Nov. 11</u> , 19 <u>56</u> , to <u>Dec. 15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec. 12</u> , 19 <u>58</u> , and that death occurred at <u>1245 A.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>1806 FOX ST.</u>		DATE SIGNED <u>DEC 18 '58</u>	
ACTUAL SIGNATURE <u>James L. Laubach</u>		M.D. _____	
PHYSICIAN'S NAME (Type) <u>JAMES L. LAUBACH</u>		<u>HYATTSVILLE, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/17/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Center Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Center, Perry County, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 18 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. PLACE OF DEATH</p>	
<p>7. OCCUPATION</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MANNER OF DEATH</p>		<p>10. SIGNATURE OF PHYSICIAN</p>	
<p>11. SIGNATURE OF REGISTRAR</p>		<p>12. SIGNATURE OF WITNESSES</p>	
<p>13. SIGNATURE OF DECEASED</p>		<p>14. SIGNATURE OF NEXT OF KIN</p>	
<p>15. SIGNATURE OF BURIAL OFFICIAL</p>		<p>16. SIGNATURE OF CHURCH OFFICIAL</p>	
<p>17. SIGNATURE OF FUNERAL HOME</p>		<p>18. SIGNATURE OF CEMETERY</p>	
<p>19. SIGNATURE OF HEALTH DEPARTMENT</p>		<p>20. SIGNATURE OF COUNTY CLERK</p>	
<p>21. SIGNATURE OF STATE DEPARTMENT OF HEALTH</p>		<p>22. SIGNATURE OF U.S. DEPARTMENT OF HEALTH</p>	

STATE CLERK

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES.

13920 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 10. YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2804 BYRON COURT				d. STREET ADDRESS 2804 BYRON COURT		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELEANORA ELIZABETH BRADLEY				4. DATE OF DEATH Month Day Year DECEMBER 21 1958			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/4/88		9. AGE (In years last birthday) 70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME THOMAS WENDEL BOLLMAN				14. MOTHER'S MAIDEN NAME LAURA JANE BOLLMAN CASSIDY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis (c) Diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 10 yrs. 3 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Kimmel's and Wilson Syndrome							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 — p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 19 55 , to Dec , 19 58 , that I last saw the deceased alive on Dec 21 , 19 58 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ralph F. Patten M.D.				ADDRESS (Street, city or town, state) 8641-Coburn Rd Silver Spring Md		DATE SIGNED Dec 24 58	
PHYSICIAN'S NAME (Type) RALPH F. PATTEN							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-23-58		22c. NAME OF CEMETERY OR CREMATORY CONGRESSIONAL CEM.		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wm Lee's Sons Co				ADDRESS Wash D.C.		24a. REC'D BY REGISTRAR DEC 24 '58	
				24b. REGISTRAR'S SIGNATURE C. H. S. Howard			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13921 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>22 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>Route 1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>Tyler</u> Last <u>Briggs</u>				4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>19 58</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/19/82</u>		
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gidding D. Briggs</u>				14. MOTHER'S MAIDEN NAME <u>Ida Sparo</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Paul F. Briggs</u>		Address <u>Route 1</u> <u>Germantown, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> <u>541.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Peritonitis</u> DUE TO (c) <u>Perforated Duodenal Ulcer</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>1 day</u> <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumophagus Vulgaris</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>11/10/58</u> , 19____, to <u>12/3/58</u> , 19____, that I last saw the deceased alive on <u>Dec. 3</u> , 19 <u>58</u> , and that death occurred at <u>10:25 AM</u> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>Manuel P. Landman</u> M.D.				ADDRESS (Street, city or town, state) <u>927 Pershing Dr. Silver Spring, Md.</u>				
DATE SIGNED _____								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-5-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>		22d. LOCATION (City, town, or county) _____ (State) <u>Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Shirley B. Garner</u>				ADDRESS <u>Gaithersburg Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 5 '58</u>		
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13922 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13875

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montg</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg. Rural</u> c. LENGTH OF STAY IN 1b <u>2 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Gaithersburg. Rural. Washington Grove</u> d. STREET ADDRESS <u>Rural</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Franklin</u> Last <u>Britton</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>26</u> Year <u>19 58</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 15th 1938</u>		9. AGE (In years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>11</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed. School.</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Gaithersburg (Rural) Md. U S A</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Louis A. Britton</u>						14. MOTHER'S MAIDEN NAME <u>Hilda Gaither</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>MA</u> <u>Louis A. Britton. Gaithersburg. RFD #2</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Epileptic Seizure</u> DUE TO <u>353.3</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (c), stating the underlying cause lost. DUE TO <u></u> (c) <u></u>												INTERVAL BETWEEN ONSET AND DEATH <u>Fond died in bed</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of epileptic seizures since childhood</u>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.														20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u></u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Frank J. Broecker</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED			
EXAMINER'S NAME (Type) <u>FRANK J. BROECKER</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-27-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12-28-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>				22d. LOCATION (City, town, or county) (State) <u>Gaithersburg Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner. Gaithersburg. Md.</u>						24a. REC'D BY REGISTRAR DATE <u>DEC 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

FOR STATE
HEALTH DEPT.

13-23
MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		COUNTY	
MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ACCIDENTS	
FAMILY HISTORY		SOCIAL HISTORY		OCCUPATION		EDUCATION		RELIGIOUS BELIEFS	
TESTS PERFORMED		RESULTS		LABORATORY		PATHOLOGICAL		TOXICOLOGICAL	
POSTMORTEM		AUTOPSY		ORGANS		CELLS		TISSUES	
FINDINGS		CONCLUSIONS		REMARKS		SIGNATURE		TITLE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13923

CERTIFICATE OF DEATH

13876

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville		c. LENGTH OF STAY IN 1b 75 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		X d. STREET ADDRESS Poolesville	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Katherine Middle Brooks Last		4. DATE OF DEATH Month Dec Day 5 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17-1870
9. AGE (In years last birthday) yrs. 88		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife in own home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Litten		14. MOTHER'S MAIDEN NAME Margaret Frye	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Harold Brooks, Poolesville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Generalized Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 36 hours (7ch) 18 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 49 , to 5 Dec , 19 58 , that I last saw the deceased alive on 5 Dec , 19 58 , and that death occurred at 6 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baynesville, Md. DATE SIGNED 6 Dec 58 ACTUAL SIGNATURE John M. Smith PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 8-1958	
22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Boallsville Md	
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton		24a. REC'D BY REGISTRAR DEC 10 '58	
ADDRESS Baynesville Md		24b. REGISTRAR'S SIGNATURE Clifford L. Hume	

1991-1992

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13924

CERTIFICATE OF DEATH

13877

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Florida</i> b. COUNTY <i>Pinellas</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				c. LENGTH OF STAY IN 1b <i>7 months</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>571 University Blvd. East</i>				d. STREET ADDRESS <i>7972 2nd Ave, South</i>			
3. NAME OF DECEASED (Type or print) <i>EDWARD</i> First <i>Reilly</i> Middle <i>BROWN</i> Last				4. DATE OF DEATH Month <i>12</i> Day <i>22</i> Year <i>1958</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5/19/1880</i>	
9. AGE (In years last birthday) <i>78</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <i>McKeesport, Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Oliver Brown</i>				14. MOTHER'S MAIDEN NAME <i>Sarah J. Brashear</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT <i>Mrs. Rosemary E. Cook</i>				Address <i>7972 2nd Ave, St. Petersburg, Florida</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>491X Congestive failure</i> DUE TO <i>Bronchopneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO (c) <i></i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>1 day</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral Thrombosis</i> <i>Uremia</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>11/15</i> , 19 <i>58</i> , to <i>12/22</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>12/22</i> , 19 <i>58</i> , and that death occurred at <i>8:15 P.</i> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Eino Magi</i>				ADDRESS (Street, city or town, state) <i>918 University Blvd. E., Silver Spring, Md.</i>			
DATE SIGNED <i>12/22/1958</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>12-26-58</i>				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY <i>Glenwood</i>				22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. William Lee's Sons Co.</i>				ADDRESS <i>300-4th St. N.</i>			
24a. REC'D BY REGISTRAR <i>DEC 29 '58</i>				24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12084

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "1880-01-01"]		PLACE OF BIRTH [Faint text, possibly "Boston, Mass."]	
OCCUPATION [Faint text, possibly "Teacher"]		MARITAL STATUS [Faint text, possibly "Married"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		DATE OF DEATH [Faint text, possibly "1925-03-15"]		PLACE OF DEATH [Faint text, possibly "Home"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13878

13925

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery P.G.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 hrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> 16-17-2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12245 Blue Hill Rd</u>			d. STREET ADDRESS <u>914 Glazewood Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Robert E. Brown JR.</u>			4. DATE OF DEATH <u>Dec 10 1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-21--01</u>		9. AGE (In years last birthday) <u>57</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Burner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Eng. Chemist</u>		11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>	
13. FATHER'S NAME <u>ROBERT E. Brown</u>			14. MOTHER'S MAIDEN NAME <u>ELLA SACKETT</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>YES</u>		17. INFORMANT Address <u>Mrs. Laura H. Brown, 914 Glazewood Avenue, Takoma Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-10-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/15/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>	
				22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Zioka</u>		ADDRESS <u>WARNER E. PUMPHREY, INC. SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 18 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>	

STATE OF
MASSACHUSETTS

1925

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1925

DATE OF DEATH
1925

RESIDENT

PLACE OF DEATH

AGE
SEX

CAUSE OF DEATH
MANNER OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13926 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13879

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brinklow c. LENGTH OF STAY IN life life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brinklow d. STREET ADDRESS Brinklow e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Catherine Budd First Middle Last 4. DATE OF DEATH Dec. 6, 1958 Month Day Year		5. SEX female 6. COLOR OR RACE Colored 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 12/31/1887 9. AGE (In years last birthday) 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework 10b. KIND OF BUSINESS OR INDUSTRY Maryland 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME John White 14. MOTHER'S MAIDEN NAME Sophia Bacon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. NO 17. INFORMANT Chas. White Gaithersburg Address RED Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1st & 2nd degree burns and exposure DUE TO (c) Found dead on floor of her home INTERVAL BETWEEN ONSET AND DEATH Found dead on floor of her home	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Unknown, Probably from oil lamp. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. Unknown, Probably from oil lamp. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown, Probably from oil lamp. 20c. TIME OF INJURY Month, Day, Year 12/5/58 Hour 1:00 p. m. 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home 20f. (City or town) (County) (State) Brinklow Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/10/58	
22a. BURIAL, CREMATION, or other disposition (Specify) Burial 22b. DATE THEREOF 12/10/58 22c. NAME OF CEMETERY OR CREMATORY Sandy Spring, 22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swoode ADDRESS Rockville, Md. 24a. REC'D BY REGISTRAR DATE DEC 12 '58 24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13927 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13880

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattstown</u>		c. LENGTH OF STAY IN 1b <u>DOA.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rural - on farm</u>			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Edgar Luther Burdette</u>			4. DATE OF DEATH <u>Dec 31</u> 19 <u>58</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-25-1886</u>		9. AGE (In years last birthday) <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>live stock dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Luther Burdette</u>			14. MOTHER'S MAIDEN NAME <u>Ellen Cistocil</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Bernard Burdette -</u> Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in corn field</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-31-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 3, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hyattstown Methodist Cem.</u>	
				22d. LOCATION (City, town, or county) (State) <u>Hyattstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. Burdette, Hyattstown, Maryland</u>			24a. REC'D BY REGISTRAR <u>JAN 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1952 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF DEATH [REDACTED]		5. TIME OF DEATH [REDACTED]		6. PLACE OF DEATH [REDACTED]	
7. OCCUPATION [REDACTED]		8. CAUSE OF DEATH [REDACTED]		9. MANNER OF DEATH [REDACTED]	
10. SIGNATURE OF EXAMINER [REDACTED]		11. SIGNATURE OF WITNESS [REDACTED]		12. SIGNATURE OF CORONER [REDACTED]	
13. SIGNATURE OF JURY [REDACTED]		14. SIGNATURE OF JURY [REDACTED]		15. SIGNATURE OF JURY [REDACTED]	
16. SIGNATURE OF JURY [REDACTED]		17. SIGNATURE OF JURY [REDACTED]		18. SIGNATURE OF JURY [REDACTED]	
19. SIGNATURE OF JURY [REDACTED]		20. SIGNATURE OF JURY [REDACTED]		21. SIGNATURE OF JURY [REDACTED]	
22. SIGNATURE OF JURY [REDACTED]		23. SIGNATURE OF JURY [REDACTED]		24. SIGNATURE OF JURY [REDACTED]	
25. SIGNATURE OF JURY [REDACTED]		26. SIGNATURE OF JURY [REDACTED]		27. SIGNATURE OF JURY [REDACTED]	
28. SIGNATURE OF JURY [REDACTED]		29. SIGNATURE OF JURY [REDACTED]		30. SIGNATURE OF JURY [REDACTED]	
31. SIGNATURE OF JURY [REDACTED]		32. SIGNATURE OF JURY [REDACTED]		33. SIGNATURE OF JURY [REDACTED]	
34. SIGNATURE OF JURY [REDACTED]		35. SIGNATURE OF JURY [REDACTED]		36. SIGNATURE OF JURY [REDACTED]	
37. SIGNATURE OF JURY [REDACTED]		38. SIGNATURE OF JURY [REDACTED]		39. SIGNATURE OF JURY [REDACTED]	
40. SIGNATURE OF JURY [REDACTED]		41. SIGNATURE OF JURY [REDACTED]		42. SIGNATURE OF JURY [REDACTED]	
43. SIGNATURE OF JURY [REDACTED]		44. SIGNATURE OF JURY [REDACTED]		45. SIGNATURE OF JURY [REDACTED]	
46. SIGNATURE OF JURY [REDACTED]		47. SIGNATURE OF JURY [REDACTED]		48. SIGNATURE OF JURY [REDACTED]	
49. SIGNATURE OF JURY [REDACTED]		50. SIGNATURE OF JURY [REDACTED]		51. SIGNATURE OF JURY [REDACTED]	
52. SIGNATURE OF JURY [REDACTED]		53. SIGNATURE OF JURY [REDACTED]		54. SIGNATURE OF JURY [REDACTED]	
55. SIGNATURE OF JURY [REDACTED]		56. SIGNATURE OF JURY [REDACTED]		57. SIGNATURE OF JURY [REDACTED]	
58. SIGNATURE OF JURY [REDACTED]		59. SIGNATURE OF JURY [REDACTED]		60. SIGNATURE OF JURY [REDACTED]	
61. SIGNATURE OF JURY [REDACTED]		62. SIGNATURE OF JURY [REDACTED]		63. SIGNATURE OF JURY [REDACTED]	
64. SIGNATURE OF JURY [REDACTED]		65. SIGNATURE OF JURY [REDACTED]		66. SIGNATURE OF JURY [REDACTED]	
67. SIGNATURE OF JURY [REDACTED]		68. SIGNATURE OF JURY [REDACTED]		69. SIGNATURE OF JURY [REDACTED]	
70. SIGNATURE OF JURY [REDACTED]		71. SIGNATURE OF JURY [REDACTED]		72. SIGNATURE OF JURY [REDACTED]	
73. SIGNATURE OF JURY [REDACTED]		74. SIGNATURE OF JURY [REDACTED]		75. SIGNATURE OF JURY [REDACTED]	
76. SIGNATURE OF JURY [REDACTED]		77. SIGNATURE OF JURY [REDACTED]		78. SIGNATURE OF JURY [REDACTED]	
79. SIGNATURE OF JURY [REDACTED]		80. SIGNATURE OF JURY [REDACTED]		81. SIGNATURE OF JURY [REDACTED]	
82. SIGNATURE OF JURY [REDACTED]		83. SIGNATURE OF JURY [REDACTED]		84. SIGNATURE OF JURY [REDACTED]	
85. SIGNATURE OF JURY [REDACTED]		86. SIGNATURE OF JURY [REDACTED]		87. SIGNATURE OF JURY [REDACTED]	
88. SIGNATURE OF JURY [REDACTED]		89. SIGNATURE OF JURY [REDACTED]		90. SIGNATURE OF JURY [REDACTED]	
91. SIGNATURE OF JURY [REDACTED]		92. SIGNATURE OF JURY [REDACTED]		93. SIGNATURE OF JURY [REDACTED]	
94. SIGNATURE OF JURY [REDACTED]		95. SIGNATURE OF JURY [REDACTED]		96. SIGNATURE OF JURY [REDACTED]	
97. SIGNATURE OF JURY [REDACTED]		98. SIGNATURE OF JURY [REDACTED]		99. SIGNATURE OF JURY [REDACTED]	
100. SIGNATURE OF JURY [REDACTED]		101. SIGNATURE OF JURY [REDACTED]		102. SIGNATURE OF JURY [REDACTED]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13928

CERTIFICATE OF DEATH

Reg. Dist. No.

13881

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fairland Nursing Home		d. STREET ADDRESS 4728 -46th Street, N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SONIA Middle BURDWISE Last		4. DATE OF DEATH Month December Day 19 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1890
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Morris Ichelson		14. MOTHER'S MAIDEN NAME Charlotte Spivak	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Mrs. Harry Fleisher -4728 -46th Street, N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Vascular Accident DUE TO (c) Arteriosclerosis (Generalized)		INTERVAL BETWEEN ONSET AND DEATH 1 day 7 weeks 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 4, 1958 , to Dec. 19, 1958 , that I lost the deceased on Dec. 19, 1958 , and that death occurred at 8:15 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel Diener M.D. 4201 Mass. Ave. N.W. Wash. D.C.		DATE SIGNED 12/19/58	
PHYSICIAN'S NAME (Type) DR. SAMUEL DIENER 4201 MASS. AVE. N.W. WASH. D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-21-58	
22c. NAME OF CEMETERY OR CREMATORY Har Judah Cemetery		22d. LOCATION (City, town, or county) (State) Delaware County Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Lanzansky & Sons-3501 14th St., N.W.		24a. REC'D BY REGISTRAR DEC 22 '58	
24b. REGISTRAR'S SIGNATURE			

13863 CERTIFICATE OF DEATH

13882

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>Washington D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park, Wash. 12, D.C.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
c. LENGTH OF STAY IN 1b <u>10-7-58</u> <u>12-23-58</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Hosp. + Sanatorium</u>				d. STREET ADDRESS <u>1615 Q St. N.W. Cairo Hotel</u>			
3. NAME OF DECEASED (Type or print) First <u>Ross</u> Middle <u>Angus</u> Last <u>Burley</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>6-26-93</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, if deceased) <u>Controller - Army</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T. retired</u>			
11. BIRTHPLACE (State or foreign country) <u>Canada</u>				12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>			
13. FATHER'S NAME <u>Amos E. Burley</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Gordnier</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes - WWII + W.W. II</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Hospital Records</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, rt. lower lobe</u> DUE TO <u>904.9</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cotrimoxazole of spine spread of infection</u> DUE TO <u>6 months</u> (c) <u>Trauma to legs and back</u> <u>6 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes mellitus</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>an Africa - fell in July, 1958 - striking legs & back</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) <u>an Africa - fell in July, 1958 - striking legs & back</u>			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>1958</u> Hour a.m. <u> </u> p.m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Henleyville, Belgian Congo</u>				20f. (City or town) (County) (State) <u>Henleyville, Belgian Congo</u>			
21. I certify that I attended the deceased from <u>Oct 7, 1958</u> , to <u>12-23-1958</u> , that I last saw the deceased alive on <u>12-22, 1958</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jason Geiger</u>				DATE SIGNED <u>12-23-58</u>			
PHYSICIAN'S NAME (Type) <u>JASON GEIGER, M.D.</u>				ADDRESS <u>Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>12/24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Ziska</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13883

13864

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7301 Cedar Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harold Lynn Butler</u>		4. DATE OF DEATH <u>12-23-1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cal driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN CAB (OWNER)</u>	
11. BIRTHPLACE (State or foreign country) <u>Mex</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isidore Butler</u>		14. MOTHER'S MAIDEN NAME <u>Louise Wagner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-01-4573</u>	
17. INFORMANT <u>Margie Corey (Daughter)</u>		Address <u>Chillum md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary accension</u> Conditions, if any, which gave rise to immediate cause (b) <u>on bed room floor</u> (c) <u>from</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC 26, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FT LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BUDENSBURG, PRGO, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Hall</u>		24a. REC'D BY REGISTRAR <u>DEC 29 58</u>	
ADDRESS <u>254 CARROLL ST. N.W.</u>		24b. REGISTRAR'S SIGNATURE <u>William J. Hall</u>	

13929

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>12 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>Rockville R.F.D. #1</u>			
3. NAME OF DECEASED (Type or print) <u>EMMA EMMERS BUTT</u>				4. DATE OF DEATH <u>Dec. 16</u> 19 <u>58</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 25 1889</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Torrey Butt</u>				14. MOTHER'S MAIDEN NAME <u>Annie Westnedge</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Flora L. Butt - Above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to the immediate cause (a), stating the <u>under</u> lying cause last. (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) <u>ARTERIAL HYPERTENSION</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 HOURS</u> <u>20 YEARS</u> <u>25 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>58</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>August</u> , 19 <u>57</u> , to <u>DEC. 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>DEC. 15</u> , 19 <u>58</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gordon S. Rosenberger</u> M.D.				ADDRESS (Street, city or town, state) <u>26 N Summit Ave Gaithersburg, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Gordon S. Rosenberger</u>				DATE SIGNED <u>12/16/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DEC 19 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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13930

MEDICAL CERTIFICATION

Dr. Broschart notified 11:35 A.M.

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M.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
SM 9/55

9VVVVVV VxVV

13931

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home		d. STREET ADDRESS 3726 Conn. Ave., N.W.	
3. NAME OF DECEASED (Type or print) First Evelyn Middle D. Last Caldwell		4. DATE OF DEATH Month 12 Day 23 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/28/1880
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR: Months 78 Days 23 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired -- Saleswoman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Paris, Texas		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert E. Dollman		14. MOTHER'S MAIDEN NAME Elizabeth Cunningham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Evelyn D. Caldwell-		Address 3726 Conn. Ave., N.W. Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio-sclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 48 hr 10 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic myocarditis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct , 1953, to Dec 23 , 1958, that I last saw the deceased alive on Dec 22 , 1958, and that death occurred at 9:00 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John V. Dolan M.D.		ADDRESS (Street, city or town, state) 3100 Conn Ave Wash D.C. DATE SIGNED 12/23/58	
PHYSICIAN'S NAME (Type) John V. Dolan			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/27/58	22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	22d. LOCATION (City, town, or county) (State) Montgomery County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W.		24a. REC'D BY REGISTRAR DATE DEC 29 '58	
24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral-director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

NAME OF DECEASED JOHN F. JOHNSON		SEX Male		AGE 45	
DATE OF DEATH Jan 15 1933		TIME OF DEATH 10:30 AM		PLACE OF DEATH 325 North Ave.	
CAUSE OF DEATH Coronary Thrombosis		DISEASE OR INJURY None		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. F. Johnson		SIGNATURE OF WITNESSES J. F. Johnson		SIGNATURE OF DECEASED J. F. Johnson	
SIGNATURE OF REGISTRAR J. F. Johnson		SIGNATURE OF CLERK J. F. Johnson		SIGNATURE OF JURY J. F. Johnson	

This is to certify that the above is a true and correct copy of the original as the same appears in the records of the State Department of Health.

J. F. JOHNSON
 REGISTRAR

J. F. JOHNSON
 CLERK

J. F. JOHNSON
 JURY

1 ~~2~~
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13932 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13888

Item 7 Film 236 12-12-58 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Faithsburg</u>		c. LENGTH OF STAY IN 1b <u>1 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Faithsburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7 Meem Ave</u>				d. STREET ADDRESS <u>7 Meem Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nelson Joseph Calif</u>				4. DATE OF DEATH <u>12-1-58</u> 19 <u>58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 4 1904</u>		9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pub. School</u>		11. BIRTHPLACE (State or foreign country) <u>Mass</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Calif</u>				14. MOTHER'S MAIDEN NAME <u>Ann B Warren</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>570-10-0498</u>		17. INFORMANT <u>Helen Calif</u> Address <u>Stim 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		12-1-58	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 5 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W Barber</u> ADDRESS <u>Laytonsville, Md</u>				24a. REC'D BY REGISTRAR <u>DEC 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. House</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13933

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 52 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Cheltenham 16X-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS Naval Radio Station - Qtrs. 3			
3. NAME OF DECEASED (Type or print) First Middle Last Albert James CARNEY				4. DATE OF DEATH Month Day Year December 17 19 58			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-9-81		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager		10b. KIND OF BUSINESS OR INDUSTRY Meat Packing		11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James CARNEY				14. MOTHER'S MAIDEN NAME Anna MC NAMARA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissecting abdominal aneurysm 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma urinary bladder							INTERVAL BETWEEN ONSET AND DEATH 6 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 26, 1958 , to December 17, 1958 , that I last saw the deceased alive on December 17, 1958 , and that death occurred at 11:40AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Howard S. Irons M.D. U. S. Naval Hospital, NMMC 12-17-58							
ACTUAL SIGNATURE Howard S. Irons				PHYSICIAN'S NAME (Type) Howard S. IRONS, LT, MC, USN Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-19-58		22c. NAME OF CEMETERY OR CREMATORY St. John's Church Cemetery Clinton Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros ADDRESS Simmons Bros., 1661 Good Hope Rd., SE, Wash., DC				24a. REC'D BY REGISTRAR DEC 19 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13934

CERTIFICATE OF DEATH

13890

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) 3707 Leland Street		d. STREET ADDRESS 3707 Leland Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANCES Middle GERTRUDE Last CARROLL		4. DATE OF DEATH Month December Day 2 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/7/91
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 4 Days 25	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME Henry Ruppert		14. MOTHER'S MAIDEN NAME Sophie Rebstock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Robert E. Phelps-Item#2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Symptomatic (reticulohyaline type) 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month 19 Day 19 Year 1958 Hour o. m. p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January, 1957 to Dec 2 , 1958, that I last saw the deceased alive on Dec 1 , 1958, and that death occurred at 5:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE BLAINE H. EIG.		DATE SIGNED Dec 2, 1958	
PHYSICIAN'S NAME (Type) BLAINE H. EIG.		M.D. 8641 Galesville Rd Silver Spring, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/5/58	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey - Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE DEC 5 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13892

CERTIFICATE OF DEATH

Reg. Dist. No.

13891

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>206 Martin's Lane, Rockville</u>		d. STREET ADDRESS <u>206 Martin's Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Louis D. CARROLL</u>		4. DATE OF DEATH <u>12-6-1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-17-1867</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PORTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wesley Carroll</u>		14. MOTHER'S MAIDEN NAME <u>Margaret E. Lunknow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Rachael Carroll</u>		Address <u>206 Martins lane Rockville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Bilateral Broncho-pneumonia</u> DUE TO <u>Generalized debility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized debility</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1958</u> , to <u>Dec. 6, 1958</u> , that I last saw the deceased alive on <u>Dec. 4, 1958</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>RD1, Catthersburg, Md.</u>		DATE SIGNED <u>12-6-58</u>	
ACTUAL SIGNATURE <u>Oliver E. Jackson</u>			
PHYSICIAN'S NAME (Type) <u>Robert L. Sworden</u>			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/9/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Haiti.,</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sworden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13935

CERTIFICATE OF DEATH

13892

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11,701 BERWICK ROAD		d. STREET ADDRESS 11,701 BERWICK ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARIA Middle McLEAN Last CARSON		4. DATE OF DEATH Month DEC. Day 1 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/28/69
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) CLEVELAND, OHIO
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME DANIEL B. McLEAN		14. MOTHER'S MAIDEN NAME RACHEL FRAZIER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Address Miss Rachel L. Carson, 11,701 Berwick Rd. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 8 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 52 , 19 52 to Dec 1 , 19 58 , that I last saw the deceased alive on Nov 30 , 19 58 , and that death occurred at 6:05 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Michel M. Healy		DATE SIGNED 12/1/58	
PHYSICIAN'S NAME (Type) MICHEL M. HEALY		ADDRESS (Street, city or town, state) Washington, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/3/58	
22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC Raymond A. Zuka		24a. REC'D BY REGISTRAR DATE DEC 2 '58	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

MARTLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13936 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13893

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookmont</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookmont</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4002 Virginia Place</u>		e. STREET ADDRESS <u>4002 Virginia Place</u>	
3. NAME OF DECEASED (Type or print) <u>Herbert Lincoln Carlkins</u>		4. DATE OF DEATH <u>Dec 22 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-6-1860</u>
9. AGE (In years last birthday) <u>98</u> yrs.		10. IF UNDER 1 YEAR: Months <u>22</u> Days <u>22</u> Hours <u>19</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rev.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mass.</u>	
11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Jonathan Carlkins</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Campbell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>12-22-58</u>	
17. INFORMANT <u>Charles Carlkins (son)</u>		Address <u>Stu</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>4341</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Heart collapsed on bed room floor</u> DUE TO (c) <u>floor</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Heart collapsed on bed room floor</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		22b. DATE THEREOF <u>12/26/58</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Watertown, Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		24a. REC'D BY REGISTRAR <u>DEC 24 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kirsch</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 14
13038 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH
1900

NAME

AGE

SEX

RACE

RELATIONSHIP

RESIDENCE

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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13937

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 5023 Chadwick Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Herbert (n) CHAPMAN				4. DATE OF DEATH Month Day Year December 24 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 August 1909	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles R. CHAPMAN				14. MOTHER'S MAIDEN NAME Letha (n) DENTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO.		17. INFORMANT Wife Louise C. CHAPMAN (Same as #2) Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 cirrhosis of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) alzheimer's disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2-3 years 2-3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 15 Sept , 19 58 , to 24 December , 19 58 , that I last saw the deceased alive on 24 December , 19 58 , and that death occurred at 12:07 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James M. Young M.D. U.S. Naval Hospital, NNM, Bethesda, Md. 12-27-58							
ACTUAL SIGNATURE James M. Young		PHYSICIAN'S NAME (Type) James M. YOUNG, LT MC USN U.S. Naval Hospital, NNM, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-30-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey Funeral Home				ADDRESS 7557 Wis. Ave, Bethesda		24a. REC'D BY REGISTRAR DEC 31 '58	
						24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

TO THE REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO. 10-1234

<p>1. Name of deceased: <u>JOHN A. SMITH</u></p>	
<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>10-15-1915</u></p>	
<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>11-10-1965</u></p>	
<p>6. Place of death: <u>HOME</u></p>	
<p>7. Cause of death: <u>HEART DISEASE</u></p>	
<p>8. Manner of death: <u>NATURAL</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>	
<p>10. Signature of registrar: <u>[Signature]</u></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13938

CERTIFICATE OF DEATH

Reg. Dist. No.

13894

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) Suburban Hospital				d. STREET ADDRESS 4501 Middleton Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) WILLIAM DONALDSON CLARK				4. DATE OF DEATH Month December Day 14 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1872	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months 4 Days 10	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.		11. BIRTHPLACE (State or foreign country) New York, N. Y.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Frank Clark				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Helen Clark Shaw-Item# 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) Coronary Embolism DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 5 days Delayed			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Jan , 19 50 , to Dec , 19 58 , that I last saw the deceased alive on Dec 13 , 19 58 , and that death occurred at 12:20 A from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo Donovan M.D.				ADDRESS (Street, city or town, state) 8016 Georgetown Rd. Bethesda, Md.			
DATE SIGNED 12/18/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/17/58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Md.				24a. REC'D BY REGISTRAR DATE DEC 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

13939

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 24 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Key West c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48 X-3 d. STREET ADDRESS Coral Isle Trailer Park e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bryan Middle Lee Last CLAUNCH			4. DATE OF DEATH Month December Day 8 Year 19 58				
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 10-14-58		9. AGE (In years last birthday) yrs. 1 Months 24 Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME James I CLAUNCH			14. MOTHER'S MAIDEN NAME Patsy R. ARNOLD				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT OFFICIAL NAVY RECORDS Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infectious Congestive Heart Failure 7545 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from November 14, 19 58 , to December 8, 19 58 , that I last saw the deceased alive on December 8, 19 58 , and that death occurred at 1:58 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Kenneth W. Sell M.D. U. S. Naval Hospital, NNM 12-8-58 PHYSICIAN'S NAME (Type) Kenneth W. Sell, LT, MSC, USN Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 12-10-58		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Tuscon Arizona			
23. FUNERAL DIRECTOR'S SIGNATURE Adams Funeral Home, 4748 Wisc. Ave., NW, Wash,		ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 11 '58			
24b. REGISTRAR'S SIGNATURE Arthur E. Hanks							

9VVVVVVVVXVV

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1893

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PERIOD OF ILLNESS

PREVAILING DISEASE

DATE OF BURIAL

PLACE OF BURIAL

SIGNATURE OF PHYSICIAN

SIGNATURE OF MINISTER

SIGNATURE OF CORONER

SIGNATURE OF JURY

SIGNATURE OF VENDOR

DATE OF REGISTRATION

PLACE OF REGISTRATION

NAME OF REGISTRAR

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PERIOD OF ILLNESS

PREVAILING DISEASE

DATE OF BURIAL

PLACE OF BURIAL

SIGNATURE OF PHYSICIAN

SIGNATURE OF MINISTER

SIGNATURE OF CORONER

SIGNATURE OF JURY

SIGNATURE OF VENDOR

DATE OF REGISTRATION

PLACE OF REGISTRATION

NAME OF REGISTRAR

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PERIOD OF ILLNESS

PREVAILING DISEASE

DATE OF BURIAL

PLACE OF BURIAL

SIGNATURE OF PHYSICIAN

SIGNATURE OF MINISTER

SIGNATURE OF CORONER

SIGNATURE OF JURY

SIGNATURE OF VENDOR

DATE OF REGISTRATION

PLACE OF REGISTRATION

NAME OF REGISTRAR

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PERIOD OF ILLNESS

PREVAILING DISEASE

DATE OF BURIAL

PLACE OF BURIAL

SIGNATURE OF PHYSICIAN

SIGNATURE OF MINISTER

SIGNATURE OF CORONER

SIGNATURE OF JURY

SIGNATURE OF VENDOR

DATE OF REGISTRATION

PLACE OF REGISTRATION

NAME OF REGISTRAR

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PERIOD OF ILLNESS

PREVAILING DISEASE

DATE OF BURIAL

PLACE OF BURIAL

SIGNATURE OF PHYSICIAN

SIGNATURE OF MINISTER

SIGNATURE OF CORONER

SIGNATURE OF JURY

SIGNATURE OF VENDOR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13865 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13896

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47x-3</u> ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hosp.</u>		d. STREET ADDRESS <u>437 Cedar St., N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Lora</u> Middle <u>E.</u> Last <u>Clement</u>		4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-16-1890</u> # yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Editor of Magazine Review Herald</u>		11. BIRTHPLACE (State or foreign country) <u>neb</u>	
13. FATHER'S NAME <u>Edw. Clement</u>		14. MOTHER'S MAIDEN NAME <u>Melinda Rankin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hoop. Reed</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>812x Hypostatic pneumonia</u> DUE TO (b) <u>Cerebral concussion & edema</u> DUE TO (c) <u>Struck by auto</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>8 days</u> <u>12-9-58</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Related struck by auto</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>6</u> p. m. <u>12/19</u> 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) <u>Washington</u> (County) <u>DC.</u> (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brozchant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROZCHANT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>DEC 19, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON CEM.</u>		22d. LOCATION (City, town, or county) <u>RIDGE RD., HYATTSVILLE, PRINCE GEORGE, MD.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Thomas</u>		24a. REC'D BY REGISTRAR <u>DEC 22 '58</u>	
ADDRESS <u>WASH 12, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

FOR STATE
HEALTH BOARD



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 14
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13504

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JURY		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY		19. SIGNATURE OF JURY		20. SIGNATURE OF JURY	
21. SIGNATURE OF JURY		22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY		25. SIGNATURE OF JURY	
26. SIGNATURE OF JURY		27. SIGNATURE OF JURY		28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY		34. SIGNATURE OF JURY		35. SIGNATURE OF JURY	
36. SIGNATURE OF JURY		37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY		40. SIGNATURE OF JURY	
41. SIGNATURE OF JURY		42. SIGNATURE OF JURY		43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY		49. SIGNATURE OF JURY		50. SIGNATURE OF JURY	
51. SIGNATURE OF JURY		52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY		55. SIGNATURE OF JURY	
56. SIGNATURE OF JURY		57. SIGNATURE OF JURY		58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY		64. SIGNATURE OF JURY		65. SIGNATURE OF JURY	
66. SIGNATURE OF JURY		67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY		70. SIGNATURE OF JURY	
71. SIGNATURE OF JURY		72. SIGNATURE OF JURY		73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY		79. SIGNATURE OF JURY		80. SIGNATURE OF JURY	
81. SIGNATURE OF JURY		82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY		85. SIGNATURE OF JURY	
86. SIGNATURE OF JURY		87. SIGNATURE OF JURY		88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY		94. SIGNATURE OF JURY		95. SIGNATURE OF JURY	
96. SIGNATURE OF JURY		97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY		100. SIGNATURE OF JURY	

13940

CERTIFICATE OF DEATH

13897

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 56		d. STREET ADDRESS 13100 Ewood Lane	
d. NAME OF HOSPITAL (If not in hospital, give street address) Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Emma Last Coar		4. DATE OF DEATH Month December Day 19 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 6, 1875
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Burtonsville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Duvall Coar Burton		14. MOTHER'S MAIDEN NAME Catherine Emma McGruder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-85-2499	
17. INFORMANT Husband		Address As above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. None 19 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 4 , 19 55 , to present , 19 58 , that I last saw the deceased alive on Dec. 18 , 19 58 , and that death occurred at 3:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John B. Umhan		DATE SIGNED 8805 CONN. AVE 12/19/58	
PHYSICIAN'S NAME (Type) JOHN B. UMHAN		CHEXY CHASE 15 MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 21, 1958	
22c. NAME OF CEMETERY OR CREMATORY Union Cem.		22d. LOCATION (City, town, or county) (State) Burtonsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Donaldson		ADDRESS Laurel Md.	
24a. REC'D BY REGISTRAR DEC 23 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of deceased
2. Date of death
3. Place of death
4. Cause of death
5. Signature of physician
6. Signature of registrar
7. Date of registration

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
1900
CERTIFICATE OF DEATH

1. Name of deceased <i>John Doe</i>		2. Date of death <i>Jan 15 1900</i>	
3. Place of death <i>Home</i>		4. Cause of death <i>Heart Disease</i>	
5. Signature of physician <i>John Doe</i>		6. Signature of registrar <i>John Doe</i>	
7. Date of registration <i>Jan 15 1900</i>		8. Name of registrar <i>John Doe</i>	
9. Name of physician <i>John Doe</i>		10. Name of hospital <i>None</i>	
11. Name of funeral home <i>John Doe</i>		12. Name of undertaker <i>John Doe</i>	
13. Name of cemetery <i>John Doe</i>		14. Name of lot <i>John Doe</i>	
15. Name of interment <i>John Doe</i>		16. Name of monument <i>John Doe</i>	
17. Name of monument <i>John Doe</i>		18. Name of monument <i>John Doe</i>	
19. Name of monument <i>John Doe</i>		20. Name of monument <i>John Doe</i>	
21. Name of monument <i>John Doe</i>		22. Name of monument <i>John Doe</i>	
23. Name of monument <i>John Doe</i>		24. Name of monument <i>John Doe</i>	
25. Name of monument <i>John Doe</i>		26. Name of monument <i>John Doe</i>	
27. Name of monument <i>John Doe</i>		28. Name of monument <i>John Doe</i>	
29. Name of monument <i>John Doe</i>		30. Name of monument <i>John Doe</i>	
31. Name of monument <i>John Doe</i>		32. Name of monument <i>John Doe</i>	
33. Name of monument <i>John Doe</i>		34. Name of monument <i>John Doe</i>	
35. Name of monument <i>John Doe</i>		36. Name of monument <i>John Doe</i>	
37. Name of monument <i>John Doe</i>		38. Name of monument <i>John Doe</i>	
39. Name of monument <i>John Doe</i>		40. Name of monument <i>John Doe</i>	
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51. Name of monument <i>John Doe</i>		52. Name of monument <i>John Doe</i>	
53. Name of monument <i>John Doe</i>		54. Name of monument <i>John Doe</i>	
55. Name of monument <i>John Doe</i>		56. Name of monument <i>John Doe</i>	
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63. Name of monument <i>John Doe</i>		64. Name of monument <i>John Doe</i>	
65. Name of monument <i>John Doe</i>		66. Name of monument <i>John Doe</i>	
67. Name of monument <i>John Doe</i>		68. Name of monument <i>John Doe</i>	
69. Name of monument <i>John Doe</i>		70. Name of monument <i>John Doe</i>	
71. Name of monument <i>John Doe</i>		72. Name of monument <i>John Doe</i>	
73. Name of monument <i>John Doe</i>		74. Name of monument <i>John Doe</i>	
75. Name of monument <i>John Doe</i>		76. Name of monument <i>John Doe</i>	
77. Name of monument <i>John Doe</i>		78. Name of monument <i>John Doe</i>	
79. Name of monument <i>John Doe</i>		80. Name of monument <i>John Doe</i>	
81. Name of monument <i>John Doe</i>		82. Name of monument <i>John Doe</i>	
83. Name of monument <i>John Doe</i>		84. Name of monument <i>John Doe</i>	
85. Name of monument <i>John Doe</i>		86. Name of monument <i>John Doe</i>	
87. Name of monument <i>John Doe</i>		88. Name of monument <i>John Doe</i>	
89. Name of monument <i>John Doe</i>		90. Name of monument <i>John Doe</i>	
91. Name of monument <i>John Doe</i>		92. Name of monument <i>John Doe</i>	
93. Name of monument <i>John Doe</i>		94. Name of monument <i>John Doe</i>	
95. Name of monument <i>John Doe</i>		96. Name of monument <i>John Doe</i>	
97. Name of monument <i>John Doe</i>		98. Name of monument <i>John Doe</i>	
99. Name of monument <i>John Doe</i>		100. Name of monument <i>John Doe</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13941

CERTIFICATE OF DEATH

13898

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASH DC</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>1629 Columbia Rd. N.W.</u> APT 514			
3. NAME OF DECEASED (Type or print) <u>C. ELMER</u> First Middle Last <u>Coleman</u>				4. DATE OF DEATH <u>Dec 5</u> 19 <u>58</u> Month Day Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/31/86</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sales Manager</u>		11. BIRTHPLACE (State or foreign country) <u>Balt. MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>CHARLES E COLEMAN</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET SHERWOOD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> <u>502.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u>491X</u> (b) <u>Tracheobronchitis and bronchopneumonia</u> (c) <u>Chronic pulmonary emphysema</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Spontaneous re. pneumothorax</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>7 days</u> <u>years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11-27</u> , 19 <u>56</u> to <u>12-5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-5</u> , 19 <u>58</u> , and that death occurred at <u>11:25</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George A. Gray, Jr.</u>				ADDRESS (Street, city or town, state) <u>104 Chevy Chase Drive</u> DATE SIGNED <u>12/5/58</u>			
PHYSICIAN'S NAME (Type) <u>George A. GRAY JR. MD.</u>				<u>Chevy Chase</u> <u>15</u> <u>Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>Wash. DC</u> <u>2901 14th St., N.W.</u>				24a. REC'D BY REGISTRAR <u>DEC 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13942 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13899

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		<u>R70 & 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp</u>				d. STREET ADDRESS <u>7 Locks Rd -</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jermine</u> Middle <u>Eleanor</u> Last <u>Cooper</u>				4. DATE OF DEATH Month <u>12</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>fe</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-21-58</u>	
9. AGE (In years last birthday) <u>21</u> yrs.		IF UNDER 1 YEAR Months <u>21</u> Days <u>21</u>		IF UNDER 24 HRS. Hours <u>21</u> Min. <u>21</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Roscoe Cooper</u>				14. MOTHER'S MAIDEN NAME <u>Roberta Vinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Roberta Cooper</u>		Address <u>Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>475x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>upper Respiratory Infection</u> (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>Fatal collapsed in bed</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/14/58</u>		<u>Lincoln Park</u>		<u>Rockville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Gordon</u>				ADDRESS <u>Rockville, Md</u>		24a. REC'D BY REGISTRAR <u>DEC 17 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

2074276XV5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13943

CERTIFICATE OF DEATH

13900

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>83x-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. LENGTH OF STAY IN 1b <u>13 mos.</u>		d. STREET ADDRESS <u>1802 Key Blvd. Arlington, Va.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bartling Nursing Home</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>23</u> Year <u>19 58</u>			
3. NAME OF DECEASED (Type or print) First <u>Charity</u> Middle <u>Marta</u> Last <u>Crank</u>				5. SEX <u>Fe</u>			
6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 28, 1882</u>		9. AGE (In years last birthday) <u>76</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Elliott</u>				14. MOTHER'S MAIDEN NAME <u>Adela Hitt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs Frances Parker 1802 Key Blvd. Arlington, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Acute Cardiac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - Advanced - Generalized</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Senile Psychosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 14</u> , 19 <u>57</u> , to <u>Dec. 23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 19</u> , 19 <u>58</u> , and that death occurred at <u>9:40 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Claire A. Christman</u> M.D.				ADDRESS (Street, city or town, state) <u>9703 Riggs Rd., Adelphi, Md.</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Claire A. Christman, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/26/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elsberry Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Missouri</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac N. Morris</u> ADDRESS <u>Arlington Funeral Home 3901 North Fairfax Dr. Arlington, Virginia</u>				24a. REC'D BY REGISTRAR <u>DEC 29 1958</u> DATE <u>12/23/58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Morris</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

13000

CERTIFICATE OF DEATH

13-13

For State Use

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH Jan 15, 1874		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Carpenter		7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF DEATH Home		10. DATE OF DEATH Jan 25, 1939	
11. SIGNATURE OF PHYSICIAN J. H. Harris		12. SIGNATURE OF WITNESSES J. H. Harris		13. SIGNATURE OF DECEASED J. H. Harris		14. SIGNATURE OF FUNERAL HOME J. H. Harris		15. SIGNATURE OF REGISTRAR J. H. Harris	
16. NAME OF FUNERAL HOME J. H. Harris		17. NAME OF CEMETERY J. H. Harris		18. NAME OF BURIAL PLACE J. H. Harris		19. NAME OF INTERMENT PLACE J. H. Harris		20. NAME OF CREMATION PLACE J. H. Harris	
21. NAME OF NEXT OF KIN J. H. Harris		22. NAME OF SURVIVORS J. H. Harris		23. NAME OF DECEASED'S MOTHER J. H. Harris		24. NAME OF DECEASED'S FATHER J. H. Harris		25. NAME OF DECEASED'S SPOUSE J. H. Harris	
26. NAME OF DECEASED'S CHILDREN J. H. Harris		27. NAME OF DECEASED'S BROTHERS J. H. Harris		28. NAME OF DECEASED'S SISTERS J. H. Harris		29. NAME OF DECEASED'S UNCLE J. H. Harris		30. NAME OF DECEASED'S AUNT J. H. Harris	
31. NAME OF DECEASED'S GRANDFATHER J. H. Harris		32. NAME OF DECEASED'S GRANDMOTHER J. H. Harris		33. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. Harris		34. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. Harris		35. NAME OF DECEASED'S GREAT-UNCLE J. H. Harris	
36. NAME OF DECEASED'S GREAT-AUNT J. H. Harris		37. NAME OF DECEASED'S GREAT-GRAND-UNCLE J. H. Harris		38. NAME OF DECEASED'S GREAT-GRAND-AUNT J. H. Harris		39. NAME OF DECEASED'S GREAT-GRAND-GRANDFATHER J. H. Harris		40. NAME OF DECEASED'S GREAT-GRAND-GRANDMOTHER J. H. Harris	
41. NAME OF DECEASED'S GREAT-GRAND-GRAND-UNCLE J. H. Harris		42. NAME OF DECEASED'S GREAT-GRAND-GRAND-AUNT J. H. Harris		43. NAME OF DECEASED'S GREAT-GRAND-GRAND-GRANDFATHER J. H. Harris		44. NAME OF DECEASED'S GREAT-GRAND-GRAND-GRANDMOTHER J. H. Harris		45. NAME OF DECEASED'S GREAT-GRAND-GRAND-GRAND-UNCLE J. H. Harris	
46. NAME OF DECEASED'S GREAT-GRAND-GRAND-GRAND-AUNT J. H. Harris		47. NAME OF DECEASED'S GREAT-GRAND-GRAND-GRAND-GRANDFATHER J. H. Harris		48. NAME OF DECEASED'S GREAT-GRAND-GRAND-GRAND-GRANDMOTHER J. H. Harris		49. NAME OF DECEASED'S GREAT-GRAND-GRAND-GRAND-GRAND-UNCLE J. H. Harris		50. NAME OF DECEASED'S GREAT-GRAND-GRAND-GRAND-GRAND-AUNT J. H. Harris	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13944

CERTIFICATE OF DEATH

13901

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Indiana b. COUNTY St. Paul 52x-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Paul	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall		d. STREET ADDRESS 52x-3	
3. NAME OF DECEASED (Type or print) First MIGNON Middle CRIPPEN Last CRIPPEN		4. DATE OF DEATH Month DEC. Day 2 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/3/1870
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Indiana	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Jefferson de Bolt		14. MOTHER'S MAIDEN NAME Catherine Jane Dickey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Mrs. Geo. Lumsden;		Address Child's Road Basking Ridge, N.J.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) ESSENTIAL HYPERTENSION			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) SENILITY			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUG. 8 , 19 58 , to DEC. 2 , 19 58 , that I last saw the deceased alive on DEC. 2 , 19 58 , and that death occurred at 6:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5206 Norway St. St. Paul, Indiana DATE SIGNED 12/2/58 ACTUAL SIGNATURE Henry M. Lowden PHYSICIAN'S NAME (Type) Henry M. LOWDEN Cherry Chase, Ind.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/3/58	
22c. NAME OF CEMETERY OR CREMATORY Paul Hill Cemetery		22d. LOCATION (City, town, or county) (State) St. Paul, Indiana	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Pauline's Sons		24a. REC'D BY REGISTRAR DEC 8 '58	
ADDRESS 1756 Penna. Ave. Md		24b. REGISTRAR'S SIGNATURE Cosima S. Evans	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		SEX Male		AGE 35		DATE OF BIRTH 12-1-29		PLACE OF BIRTH MOBILE, ALA.		RACE White		RELIGION Baptist		MARRIAGE Single		OCCUPATION Lawyer		CAUSE OF DEATH Gunshot wound		PLACE OF DEATH Memphis, Tenn.		TIME OF DEATH 9:01 AM		DATE OF DEATH 4-4-68		SIGNATURE OF REGISTRAR [Signature]		OFFICE OF REGISTRAR Baltimore, Md.															
FATHER'S NAME JAMES EARL RAY, JR.		MOTHER'S NAME ADELE RAY		FATHER'S OCCUPATION Lawyer		MOTHER'S OCCUPATION Homemaker		FATHER'S PLACE OF BIRTH Mobile, Ala.		MOTHER'S PLACE OF BIRTH Mobile, Ala.		FATHER'S RELIGION Baptist		MOTHER'S RELIGION Baptist		FATHER'S MARRIAGE Married		MOTHER'S MARRIAGE Married		FATHER'S CAUSE OF DEATH Unknown		MOTHER'S CAUSE OF DEATH Unknown		FATHER'S PLACE OF DEATH Unknown		MOTHER'S PLACE OF DEATH Unknown		FATHER'S TIME OF DEATH Unknown		MOTHER'S TIME OF DEATH Unknown		FATHER'S DATE OF DEATH Unknown		MOTHER'S DATE OF DEATH Unknown		FATHER'S SIGNATURE [Signature]		MOTHER'S SIGNATURE [Signature]		FATHER'S OFFICE Baltimore, Md.		MOTHER'S OFFICE Baltimore, Md.	
DECEASED'S RESIDENCE 1000 1/2 N. 3rd St., Memphis, Tenn.		DECEASED'S OCCUPATION Lawyer		DECEASED'S PLACE OF BIRTH Mobile, Ala.		DECEASED'S RELIGION Baptist		DECEASED'S MARRIAGE Single		DECEASED'S CAUSE OF DEATH Gunshot wound		DECEASED'S PLACE OF DEATH Memphis, Tenn.		DECEASED'S TIME OF DEATH 9:01 AM		DECEASED'S DATE OF DEATH 4-4-68		DECEASED'S SIGNATURE [Signature]		DECEASED'S OFFICE Baltimore, Md.		DECEASED'S RESIDENCE 1000 1/2 N. 3rd St., Memphis, Tenn.		DECEASED'S OCCUPATION Lawyer		DECEASED'S PLACE OF BIRTH Mobile, Ala.		DECEASED'S RELIGION Baptist		DECEASED'S MARRIAGE Single		DECEASED'S CAUSE OF DEATH Gunshot wound		DECEASED'S PLACE OF DEATH Memphis, Tenn.		DECEASED'S TIME OF DEATH 9:01 AM		DECEASED'S DATE OF DEATH 4-4-68		DECEASED'S SIGNATURE [Signature]		DECEASED'S OFFICE Baltimore, Md.	

13945

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montg MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg. Rural.		c. LENGTH OF STAY IN TB 63 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		/d. STREET ADDRESS R F D #3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Forrest Franklin Crown		4. DATE OF DEATH Month Dec Day 17 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12-1895
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 7 Days 5 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Gaithersburg. Rural.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James M. Crown		14. MOTHER'S MAIDEN NAME Sarah C. Crown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Ruby Briggs Crown. Gaithersburg.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage, right hemisphere 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none INTERVAL BETWEEN ONSET AND DEATH 8 days 5 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 , 1950 , to Dec 17 , 1958 that I last saw the deceased alive on Dec 17 , 1958 , and that death occurred at 10:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm. G. Lenthum M.D.		ADDRESS (Street, city or town, state) 26 N. Summit Ave. Gaithersburg, Md.	
DATE SIGNED 12/18/58			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-20-58	
22c. NAME OF CEMETERY OR CREMATORY Rockville Union		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE DEC 22 '58		24b. REGISTRAR'S SIGNATURE Arthur A. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10-1-54

1. NAME OF DECEASED [Blank]		2. SEX [Blank]		3. AGE [Blank]		4. RACE [Blank]		5. DATE OF BIRTH [Blank]		6. PLACE OF BIRTH [Blank]		7. DATE OF DEATH [Blank]		8. PLACE OF DEATH [Blank]		9. TIME OF DEATH [Blank]		10. CAUSE OF DEATH [Blank]		11. MANNER OF DEATH [Blank]		12. SIGNATURE OF REGISTRAR [Blank]		13. SIGNATURE OF DECEASED [Blank]		14. SIGNATURE OF WITNESS [Blank]		15. SIGNATURE OF PHYSICIAN [Blank]		16. SIGNATURE OF CLERK [Blank]		17. SIGNATURE OF NURSE [Blank]		18. SIGNATURE OF OTHER [Blank]		19. SIGNATURE OF OTHER [Blank]		20. SIGNATURE OF OTHER [Blank]		21. SIGNATURE OF OTHER [Blank]		22. SIGNATURE OF OTHER [Blank]		23. SIGNATURE OF OTHER [Blank]		24. SIGNATURE OF OTHER [Blank]		25. SIGNATURE OF OTHER [Blank]		26. SIGNATURE OF OTHER [Blank]		27. SIGNATURE OF OTHER [Blank]		28. SIGNATURE OF OTHER [Blank]		29. SIGNATURE OF OTHER [Blank]		30. SIGNATURE OF OTHER [Blank]		31. SIGNATURE OF OTHER [Blank]		32. SIGNATURE OF OTHER [Blank]		33. SIGNATURE OF OTHER [Blank]		34. SIGNATURE OF OTHER [Blank]		35. SIGNATURE OF OTHER [Blank]		36. SIGNATURE OF OTHER [Blank]		37. SIGNATURE OF OTHER [Blank]		38. SIGNATURE OF OTHER [Blank]		39. SIGNATURE OF OTHER [Blank]		40. SIGNATURE OF OTHER [Blank]		41. SIGNATURE OF OTHER [Blank]		42. SIGNATURE OF OTHER [Blank]		43. SIGNATURE OF OTHER [Blank]		44. SIGNATURE OF OTHER [Blank]		45. SIGNATURE OF OTHER [Blank]		46. SIGNATURE OF OTHER [Blank]		47. SIGNATURE OF OTHER [Blank]		48. SIGNATURE OF OTHER [Blank]		49. SIGNATURE OF OTHER [Blank]		50. SIGNATURE OF OTHER [Blank]		51. SIGNATURE OF OTHER [Blank]		52. SIGNATURE OF OTHER [Blank]		53. SIGNATURE OF OTHER [Blank]		54. SIGNATURE OF OTHER [Blank]		55. SIGNATURE OF OTHER [Blank]		56. SIGNATURE OF OTHER [Blank]		57. SIGNATURE OF OTHER [Blank]		58. SIGNATURE OF OTHER [Blank]		59. SIGNATURE OF OTHER [Blank]		60. SIGNATURE OF OTHER [Blank]		61. SIGNATURE OF OTHER [Blank]		62. SIGNATURE OF OTHER [Blank]		63. SIGNATURE OF OTHER [Blank]		64. SIGNATURE OF OTHER [Blank]		65. SIGNATURE OF OTHER [Blank]		66. SIGNATURE OF OTHER [Blank]		67. SIGNATURE OF OTHER [Blank]		68. SIGNATURE OF OTHER [Blank]		69. SIGNATURE OF OTHER [Blank]		70. SIGNATURE OF OTHER [Blank]		71. SIGNATURE OF OTHER [Blank]		72. SIGNATURE OF OTHER [Blank]		73. SIGNATURE OF OTHER [Blank]		74. SIGNATURE OF OTHER [Blank]		75. SIGNATURE OF OTHER [Blank]		76. SIGNATURE OF OTHER [Blank]		77. SIGNATURE OF OTHER [Blank]		78. SIGNATURE OF OTHER [Blank]		79. SIGNATURE OF OTHER [Blank]		80. SIGNATURE OF OTHER [Blank]		81. SIGNATURE OF OTHER [Blank]		82. SIGNATURE OF OTHER [Blank]		83. SIGNATURE OF OTHER [Blank]		84. SIGNATURE OF OTHER [Blank]		85. SIGNATURE OF OTHER [Blank]		86. SIGNATURE OF OTHER [Blank]		87. SIGNATURE OF OTHER [Blank]		88. SIGNATURE OF OTHER [Blank]		89. SIGNATURE OF OTHER [Blank]		90. SIGNATURE OF OTHER [Blank]		91. SIGNATURE OF OTHER [Blank]		92. SIGNATURE OF OTHER [Blank]		93. SIGNATURE OF OTHER [Blank]		94. SIGNATURE OF OTHER [Blank]		95. SIGNATURE OF OTHER [Blank]		96. SIGNATURE OF OTHER [Blank]		97. SIGNATURE OF OTHER [Blank]		98. SIGNATURE OF OTHER [Blank]		99. SIGNATURE OF OTHER [Blank]		100. SIGNATURE OF OTHER [Blank]	
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13866 CERTIFICATE OF DEATH

13903

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSP				d. STREET ADDRESS 1805. SEEKS LANE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH LAVINA CRUM				4. DATE OF DEATH Month Day Year 12 - 5 1958			
5. SEX F	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2. 20. 72	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME NOT KNOWN				14. MOTHER'S MAIDEN NAME NOT KNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 578-12-7831D		17. INFORMANT HOSPITAL CHART			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intestinal Obstruction							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 12/3 , 19 58 , to 12/5 , 19 58 , that I last saw the deceased alive on 12/5 , 19 58 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Bennett Robin M.D.				ADDRESS (Street, city or town, state) BENNETT ROBIN, M.D. 8723 PINEY BRANCH ROAD SILVER SPRING, MARYLAND			
PHYSICIAN'S NAME (Type) Bennett Robin M.D.				DATE SIGNED 12/6/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec-8-58	22c. NAME OF CEMETERY OR CREMATORY St. Olaf Cemetery		22d. LOCATION (City, town, or county) Frederick		(State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters, 254 Carroll St NW				24a. REC'D BY REGISTRAR DATE DEC 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kiana	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13946

CERTIFICATE OF DEATH

13904

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 4 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier				16 16.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 4103 32nd Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Edward Middle A Last Curtis				4. DATE OF DEATH Month December Day 9 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 10, 1893	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min.		IF UNDER 24 HRS. Months 65 Days 65 Hours 65 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect				10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Salem Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Issac				14. MOTHER'S MAIDEN NAME Ann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES (If yes, give war or dates of service) WWI				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Hospital Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination 451X DUE TO Ruptured dissecting aneurysm of aorta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cytic Medionecrosis of aorta (c) Anterior Syphal Myocardial Infarction				INTERVAL BETWEEN ONSET AND DEATH 4 days Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anterior Syphal Myocardial Infarction				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Falls Church Va				20g. (County) Falls Church Va		20h. (State) Falls Church Va	
21. I certify that I attended the deceased from 12-5-58 , 19 58 , to 12-9-58 , 19 58 , that I last saw the deceased alive on 12-8-58 , 19 58 , and that death occurred at 3:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Falls Church Va DATE SIGNED 12-9-58							
ACTUAL SIGNATURE Carle H. Miteaue M.D.							
PHYSICIAN'S NAME (Type) Carle H. Miteaue							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/11-1958		22c. NAME OF CEMETERY OR CREMATORY Flat Meme Park		22d. LOCATION (City, town, or county) (State) Falls Church Va	
23. FUNERAL DIRECTOR'S SIGNATURE Goldberg				24a. REC'D BY REGISTRAR DATE DEC 15 '58		24b. REGISTRAR'S SIGNATURE Charles L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13947

CERTIFICATE OF DEATH

13905

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase, Md.			
c. LENGTH OF STAY IN 1b 3 1/2 Yrs.				d. STREET ADDRESS 4707 Dover Rd.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4707 Dover Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle ANNE Last DEVINE				4. DATE OF DEATH Month Dec. Day 1 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May, 20, 1867	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Ireland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME John Saxe				14. MOTHER'S MAIDEN NAME Anna Brien			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Robert Piper,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerotic heart disease DUE TO (c) year				INTERVAL BETWEEN ONSET AND DEATH 6 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May , 19 55 , to Dec. 1 , 19 58 , that I last saw the deceased alive on December 1 , 19 58 , and that death occurred at 9:20 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Elaine W. Murphy				ADDRESS (Street, city or town, state) 4812 Ellicott H NW DATE SIGNED 12-1-58			
PHYSICIAN'S NAME (Type) Elaine W. Murphy				Washington 16 DC			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		12/3/58		Shiloh		Milwaukee, Wis	
23. FUNERAL DIRECTOR'S SIGNATURE Cherry Chase Funeral Home				ADDRESS 5103 Wisconsin Ave NW		24b. REGISTRAR'S SIGNATURE REC'D BY REGISTRAR	
				DATE DEC 3 '58			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13948

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Brazil b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH First Margareth Middle None Last Dias (Type or print)				Month December Day 10 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 1, 1954	
9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Brazil	
12. CITIZEN OF WHAT COUNTRY? Brazil ✓							
13. FATHER'S NAME Alfredo Dias				14. MOTHER'S MAIDEN NAME Vani (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Period following Complete Correction of Tetralogy 754.0 DUE TO of Fallot. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Congenital							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from November 28, 1958 , to December 10, 1958 , that I last saw the deceased alive on December 10, 1958 , and that death occurred at 4:15 p. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12-11-58 ACTUAL SIGNATURE William P. Cornell M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) WILLIAM P. CORNELL, M.D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/14/58		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Rio de Janeiro, BRAZIL	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawrence Law ADDRESS 1756 R. W. M.				24a. REC'D BY REGISTRAR DATE 12/25/58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13949 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPENCERVILLE</u>		c. LENGTH OF STAY IN 1b YRS. <u>X</u> <u>SPENCERVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PEACH ORCHARD ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WEBSTER</u> Middle <u>DWYER</u> Last <u>DWYER</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>29</u> Year <u>1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 2, 1895.</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GEN BLDG TRADES</u>	
11. BIRTHPLACE (State or foreign country) <u>HOWARD COUNTY, MARYLAND.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>THOMAS DWYER</u>		14. MOTHER'S MAIDEN NAME <u>MARY TROUT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-09-0534</u>	
17. INFORMANT <u>Mrs BERNICE M. DWYER</u>		Address <u>SPENCERVILLE, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> <u>Cerebral Hemorrhage</u> DUE TO <u>Soft Xanthophlegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Arterio-sclerosis</u> DUE TO <u>Arterio-sclerosis</u> (c) <u>Arterio-sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>60 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/1</u> 19 <u>57</u> , to <u>12/29</u> 19 <u>58</u> , that I last saw the deceased alive on <u>12/28</u> 19 <u>59</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>[Signature]</u> DATE SIGNED <u>12/29/58</u>	
PHYSICIAN'S NAME (Type) <u>[Signature]</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Dec. 31, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>UNION CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>SPENCERVILLE, MONTGOMERY, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>254 Carroll St. NW.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 31 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1949 CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE, MD

13903

File No.

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>	
<p>2. Date of death: <u>10/15/49</u></p>	
<p>3. Place of death: <u>Home</u></p>	
<p>4. Age at death: <u>68</u></p>	
<p>5. Sex: <u>Male</u></p>	
<p>6. Race: <u>White</u></p>	
<p>7. Marital status: <u>Married</u></p>	
<p>8. Occupation: <u>Teacher</u></p>	
<p>9. Cause of death: <u>Heart Disease</u></p>	
<p>10. Signature of physician: <u>[Signature]</u></p>	
<p>11. Signature of registrar: <u>[Signature]</u></p>	
<p>12. Date of filing: <u>10/20/49</u></p>	

10/20/49

10/20/49

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13950 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13908

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrett Park</u>	c. LENGTH OF STAY IN 1b <u>DOA</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrett Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>B & O R R Crossing</u>		d. STREET ADDRESS <u>11013 Montrose Ave.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillia n Bray Dye</u>		4. DATE OF DEATH Month Day Year <u>Dec 27 1958 19</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/24/77</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days <u>10 2</u>	IF UNDER 24 HRS. Hours Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John W. Bray</u>	
14. MOTHER'S MAIDEN NAME <u>Ellen Spofford</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Williston L. Dye (son) Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound Fracture of skull and Multiple Injuries Extreme</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>a uto struck by train</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Operator of auto struck by freight train at B & O crossing Garrett Pk. Md.</u>	
20c. TIME OF INJURY Month, Day, Year <u>12/27 1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rk Crossing</u>	20f. (City or town) (County) (State) <u>Garrett Pk. Montg Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		DATE SIGNED <u>12/27/ 58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/30/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 2 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13951

CERTIFICATE OF DEATH

13909

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Saburton HOSPITAL</u>				e. STREET ADDRESS <u>13201 Janet Rd.</u>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Kerry Scott Engel</u>				4. DATE OF DEATH Month Day Year <u>Dec. 15 1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/10/58</u>	
9. AGE (In years last birthday) yrs. <u>5</u>		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Donald W. Engel</u>		14. MOTHER'S MAIDEN NAME <u>Enid Martha Lowe</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Donald W. Engel</u>		Address <u>3201 Janet Rd. Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.0 Shock</u> DUE TO <u>Resorptive Stenosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4 hours</u> DUE TO (c) <u>12 hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></u> <u>Constitutional anomalies: Cataract Rt. Eye; Rt. Inguinal Hernia</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 11</u> , 19 <u>58</u> , to <u>Dec 15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 15</u> , 19 <u>58</u> , and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1515 Highland Avenue Silver Spring, Md.</u> DATE SIGNED <u>George B. Spence</u>							
ACTUAL SIGNATURE <u>George B. Spence</u> M.D. <u>1515 Highland Avenue Silver Spring, Md.</u>							
PHYSICIAN'S NAME (Type) <u>G. R. SPENCE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

2074373XU3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1895

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1895

PLACE OF BIRTH		MARRIAGE	
CITY OR TOWN		CITY OR TOWN	
COUNTY		COUNTY	
DATE OF BIRTH		DATE OF DEATH	
AGE		AGE	
SEX		SEX	
OCCUPATION		OCCUPATION	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF DECEASED	
SIGNATURE OF WITNESSES		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
SIGNATURE OF CLERGYMAN		SIGNATURE OF CLERGYMAN	
SIGNATURE OF JUDGE		SIGNATURE OF JUDGE	
SIGNATURE OF SHERIFF		SIGNATURE OF SHERIFF	
SIGNATURE OF CORONER		SIGNATURE OF CORONER	
SIGNATURE OF TOWNSHIP CLERK		SIGNATURE OF TOWNSHIP CLERK	
SIGNATURE OF COUNTY CLERK		SIGNATURE OF COUNTY CLERK	
SIGNATURE OF STATE CLERK		SIGNATURE OF STATE CLERK	

RECEIVED
BALTIMORE
MAY 18 1895

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13910

13952

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u> d. STREET ADDRESS <u>1403 Blanford Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <u>William Richard English</u> First Middle Last		4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>1958</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-16-20</u>		9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Salesman</u> 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Geo. R. English</u> 14. MOTHER'S MAIDEN NAME <u>Pauline E. Fox</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>220-05-6361</u> 17. INFORMANT <u>Hosp Record.</u> Address <u> </u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u> DUE TO <u> </u> (c) <u> </u> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> </div> </div> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>																	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u>19</u> Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>Frank J. Broschart</u> EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>12-22-58</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12-24-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Cemetery</u>				22d. LOCATION (City, town, or county) <u>Thurmont, Maryland</u> (State)							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u> ADDRESS <u>Thurmont, Md.</u>						24a. REC'D BY REGISTRAR DATE <u>DEC 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>									

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Birth		6. Usual Residence		7. Cause of Death		8. Manner of Death	
9. Occupation		10. Education		11. Marital Status		12. Social History	
13. Medical History		14. Present Illness		15. Post-mortem Examination		16. Signature of Examiner	
17. Signature of Coroner		18. Signature of Physician		19. Signature of Pathologist		20. Signature of Forensic Pathologist	
21. Signature of Medical Examiner		22. Signature of Assistant Medical Examiner		23. Signature of Assistant Medical Examiner		24. Signature of Assistant Medical Examiner	
25. Signature of Assistant Medical Examiner		26. Signature of Assistant Medical Examiner		27. Signature of Assistant Medical Examiner		28. Signature of Assistant Medical Examiner	
29. Signature of Assistant Medical Examiner		30. Signature of Assistant Medical Examiner		31. Signature of Assistant Medical Examiner		32. Signature of Assistant Medical Examiner	
33. Signature of Assistant Medical Examiner		34. Signature of Assistant Medical Examiner		35. Signature of Assistant Medical Examiner		36. Signature of Assistant Medical Examiner	
37. Signature of Assistant Medical Examiner		38. Signature of Assistant Medical Examiner		39. Signature of Assistant Medical Examiner		40. Signature of Assistant Medical Examiner	
41. Signature of Assistant Medical Examiner		42. Signature of Assistant Medical Examiner		43. Signature of Assistant Medical Examiner		44. Signature of Assistant Medical Examiner	
45. Signature of Assistant Medical Examiner		46. Signature of Assistant Medical Examiner		47. Signature of Assistant Medical Examiner		48. Signature of Assistant Medical Examiner	
49. Signature of Assistant Medical Examiner		50. Signature of Assistant Medical Examiner		51. Signature of Assistant Medical Examiner		52. Signature of Assistant Medical Examiner	
53. Signature of Assistant Medical Examiner		54. Signature of Assistant Medical Examiner		55. Signature of Assistant Medical Examiner		56. Signature of Assistant Medical Examiner	
57. Signature of Assistant Medical Examiner		58. Signature of Assistant Medical Examiner		59. Signature of Assistant Medical Examiner		60. Signature of Assistant Medical Examiner	
61. Signature of Assistant Medical Examiner		62. Signature of Assistant Medical Examiner		63. Signature of Assistant Medical Examiner		64. Signature of Assistant Medical Examiner	
65. Signature of Assistant Medical Examiner		66. Signature of Assistant Medical Examiner		67. Signature of Assistant Medical Examiner		68. Signature of Assistant Medical Examiner	
69. Signature of Assistant Medical Examiner		70. Signature of Assistant Medical Examiner		71. Signature of Assistant Medical Examiner		72. Signature of Assistant Medical Examiner	
73. Signature of Assistant Medical Examiner		74. Signature of Assistant Medical Examiner		75. Signature of Assistant Medical Examiner		76. Signature of Assistant Medical Examiner	
77. Signature of Assistant Medical Examiner		78. Signature of Assistant Medical Examiner		79. Signature of Assistant Medical Examiner		80. Signature of Assistant Medical Examiner	
81. Signature of Assistant Medical Examiner		82. Signature of Assistant Medical Examiner		83. Signature of Assistant Medical Examiner		84. Signature of Assistant Medical Examiner	
85. Signature of Assistant Medical Examiner		86. Signature of Assistant Medical Examiner		87. Signature of Assistant Medical Examiner		88. Signature of Assistant Medical Examiner	
89. Signature of Assistant Medical Examiner		90. Signature of Assistant Medical Examiner		91. Signature of Assistant Medical Examiner		92. Signature of Assistant Medical Examiner	
93. Signature of Assistant Medical Examiner		94. Signature of Assistant Medical Examiner		95. Signature of Assistant Medical Examiner		96. Signature of Assistant Medical Examiner	
97. Signature of Assistant Medical Examiner		98. Signature of Assistant Medical Examiner		99. Signature of Assistant Medical Examiner		100. Signature of Assistant Medical Examiner	

ALMOND HILL

13953 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boysds</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Gaithersburg R-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Md. Route 117</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Everett V. ESTES, Jr.</u>		4. DATE OF DEATH <u>Dec 14, 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/12/1942</u>
9. AGE (In years last birthday) <u>16</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Everett V. Estes</u>		14. MOTHER'S MAIDEN NAME <u>Olive Rines</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Father</u>		Address <u>Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of 1st, 2nd & 3rd cervical vertebra</u> <u>823X</u> DUE TO <u>with severance of cord</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Auto accident</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severance of rt carotid A. and jugular vein</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Driver of auto which left highway & struck stone wall</u>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year <u>12:40 A.M. 12/14/58</u>	
20d. INJURY OCCURRED <u>While at work</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>highway</u>	
20f. (City or town) <u>Boysds Montg.</u>		(County) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/17/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Ch. Cem.</u>		22d. LOCATION (City, town, or county) <u>Darnestown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 18 58</u>	
ADDRESS <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

1-800-368-2746
www.10000hours.com

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13867 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13912

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washi San & Hosp</u>				d. STREET ADDRESS <u>14621 Peach Orchard Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>Walter</u> Last <u>Feldbush</u>				4. DATE OF DEATH Month <u>12</u> Day <u>1</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 21-1908</u> 50 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen. & Production Mgr. Rex Engraving Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Elizabeth, N. Jersey</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Walter Feldbush</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Mock</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Rosa Lee Feldbush (wife)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> DUE TO (c) <u>420.1</u> DUE TO cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF <u>12/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
1900 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF EXAMINER

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF EXAMINER

DATE OF EXAMINATION

PLACE OF EXAMINATION

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PLACE OF EXAMINATION

NAME OF EXAMINER

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF EXAMINER

DATE OF EXAMINATION

13868

CERTIFICATE OF DEATH

13913

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>—</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hosp</u>				d. STREET ADDRESS <u>1613 Harvard ST</u>			
3. NAME OF DECEASED (Type or print) <u>Hendrix (N.M.N.) Felton</u>				4. DATE OF DEATH <u>12-11-1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-24-76</u>	9. AGE (In years last birthday) <u>82</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>				13. FATHER'S NAME <u>George Felton</u>			
14. MOTHER'S MAIDEN NAME <u>Amelia Heath</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Encephalopathy.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis and</u> DUE TO (c) <u>Uremia - and coronary sclerosis.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>9-23-</u> , 19 <u>39</u> , to <u>12-11-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-10-</u> , 19 <u>58</u> , and that death occurred at <u>1:40 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>N.C. Shoemaker</u> M.D.				ADDRESS (Street, city or town, state) <u>8005 Woodbury Drive</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>N.C. Shoemaker, M.D.</u>				<u>Silver Spring, Maryland.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12/15/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> <u>2901 17th St. N.W.</u> <u>Washington 9, D.C.</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>DEC 15 58</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13954

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) 4804 Wellington Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WINFRED F. FEREDAY				4. DATE OF DEATH Month Day Year Dec. 22, 1958 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1897	9. AGE (In years last birthday) yrs. 61	IF UNDER 1 YEAR Months Days 2 10	IF UNDER 24 HRS. Hours Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. - Electrical Eng.		10b. KIND OF BUSINESS OR INDUSTRY xxx		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Thomas Fereday				14. MOTHER'S MAIDEN NAME Sara J. McKenzie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no; if unknown) No		16. SOCIAL SECURITY NO. 181-01-8215		17. INFORMANT Ruth E. Fereday-Item# 2			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 4445x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) Arterial hypertension, malignant DUE TO INTERVAL BETWEEN ONSET AND DEATH 2 wks. 16 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Quadriplegia due to previous cerebral thrombosis 1955							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 11, 1957 to Dec. 22, 1958 , that I last saw the deceased alive on Dec. 22, 1958 , and that death occurred at 2:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas A. Wildman		ADDRESS (Street, city or town, state) DATE SIGNED 3729 Morrison St., N.W., Wash., D.C. 12-22-58					
PHYSICIAN'S NAME (Type) Thomas A. Wildman		3729 Morrison St., N.W., Washington, D.C.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/27/58		22c. NAME OF CEMETERY OR CREMATORY Odd Fellows		22d. LOCATION (City, town, or county) (State) Tamaque, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE DEC 29 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13955

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>County</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN IB <u>12hrs. 20mins</u> <u>56</u> <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>				d. STREET ADDRESS <u>Cl21 Norwood Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Amon</u> Middle <u>Wallace</u> Last <u>Ford</u>				4. DATE OF DEATH Month <u>xx</u> <u>12</u> Day <u>xx</u> <u>27</u> Year <u>58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-14-15</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crane Operator - Construction Company</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Company</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>EMMETT C. FORD</u>				14. MOTHER'S MAIDEN NAME <u>Melly Hostetter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>579-14-0825</u>		17. INFORMANT <u>Dorothy Ford</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>252.0</u> DUE TO <u>acute Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>11/30/58</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>11/30/58</u> to <u>12/27/58</u> , that I last saw the deceased alive on <u>12/27/58</u> , and that death occurred at <u>10:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. W. BIRD</u>				ADDRESS (Street, city or town, state) <u>Silver Spring, MD.</u> DATE SIGNED <u>12/27/58</u>			
PHYSICIAN'S NAME (Type) <u>J. W. BIRD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/30/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>DEC 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1001

<p>1. Name of deceased: <u>JOHN DOE</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1900-01-01</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>1950-01-01</u></p>		<p>6. Place of death: <u>NEW YORK</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>1950-01-01</u></p>		<p>12. Place of registration: <u>NEW YORK</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13916

13956

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 741 EASLEY STREET				d. STREET ADDRESS 741 EASLEY STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle HAYES Last FREAS				4. DATE OF DEATH Month DEC. Day 25 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/29/62	
9. AGE (In years last birthday) 96		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEMAKER (HOMEMAKER)				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) ENGLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME EDWARD HAYES				14. MOTHER'S MAIDEN NAME ANN DOWNS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs. Katie E. Clark, 714 Easley St. Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) 20 YRS.				INTERVAL BETWEEN ONSET AND DEATH 1 DAY			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug , 19 48 , to DEC. , 19 58 , that I last saw the deceased alive on 12/23 , 19 58 , and that death occurred at 9 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE LBSnow				ADDRESS (Street, city or town, state) 9013 FLOWER AVE. SILVER SPRING, MD.			
DATE SIGNED 12/26/58							
PHYSICIAN'S NAME (Type) L. B. SNOW							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/27/58		22c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE WANNER E. PUMPHREY, INC. Raymond A. Jiska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE DEC 29 58	
24b. REGISTRAR'S SIGNATURE W. S. H. H. H.							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

M

73

MEDICAL CERTIFICATION

15

2

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13957

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13918

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney	c. LENGTH OF STAY IN lb 5 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. Co. Gen.		d. STREET ADDRESS 9915 Holmhurst Rd.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Stella Long Fuquay		4. DATE OF DEATH Dec 31 1958 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/7/97
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) N.C.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Sidney Long	
14. MOTHER'S MAIDEN NAME Ella Poythress		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 240-01-1930		17. INFORMANT Hosp. Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Thrombosis DUE TO (b) Fracture of left hip DUE TO (c) 902.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH sudden 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from bed		20c. TIME OF INJURY 4:00 o. m. 12/24 19 58	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sharon San.	
20f. (City or town) Olney (County) Montg (State) Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/31/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 1-1-59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Chapel Hill Cem.		22d. LOCATION (City, town, or county) (State) Chapel Hill, North Car.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR JAN 5 '59		24b. REGISTRAR'S SIGNATURE Charles S. Puma	

FOR STATE
HEALTH OFFICE

Montgomery

Gray

Mont. Co. Gen.

Sec. 10

James M. Gray

Mont. Co. Gen.

Sidney Long

1901-01-1950 Hosp. Record

Prisoners' Testimony

Signature of Self

Will You Sign

1900

Simon G.

Gray

Frank W. Broderick

Chapel Hill

Montgomery, Md.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13869 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13919

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		c. LENGTH OF STAY IN 1b <u>DoA</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Springs</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San & Hosp.</u>			d. STREET ADDRESS <u>10609 Edgewood Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Thomas Gaizer</u>			4. DATE OF DEATH Month Day Year <u>12 29 1958</u>		
5. SEX <u>m.</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-22-06</u>		9. AGE (In years last birthday) <u>52</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer/Draftsman PEPCO</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pot. Electric Power Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Side Water, Va.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Mr. Frederick Gaizer</u>			14. MOTHER'S MAIDEN NAME <u>Mrs. Mary Britton</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes 1/1943</u>		16. SOCIAL SECURITY NO. <u>577-05-0707</u>	17. INFORMANT <u>Lorene F. Gaizer</u> Address <u>Same as above</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Insulin malnutrition for several yrs.</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-29-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/31/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WERNER E. PUMPHREY, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DEC 31 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

13-483 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

SEE THE

DATE OF DEATH
TIME

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13958 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13920

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>14701 Good Hope Rd</u>			d. STREET ADDRESS <u>14701 Good Hope Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Gardner</u> Last			4. DATE OF DEATH Month <u>12</u> Day <u>9</u> Year <u>1958</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-23-1880</u>		9. AGE (In years last birthday) <u>78</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ky.</u>	
13. FATHER'S NAME <u>Charles Gardner</u>			14. MOTHER'S MAIDEN NAME <u>Julia Reed</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Chas Gardner (son)</u> Address <u>Stim 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<u>12-9-58</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Shipped</u>		22b. DATE THEREOF <u>12/10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>McClain Funeral Home</u>	
22d. LOCATION (City, town, or county) (State) <u>Huntington, West Va.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 12 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

100321

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16
100328 MEDICAL EXAMINER'S CERTIFICATE OF DEATH



FOR STATE
HEALTH DEPT.

DECEASED

DATE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

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RECEIVED
BALTIMORE
MAY 10 1968

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSES.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13959

CERTIFICATE OF DEATH

13921

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanitarium</u>		d. STREET ADDRESS <u>1816 Upshur St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret Jones George</u>		4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 28, 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
10c. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM JONES</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET JONES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Oliver G. Brinkman</u>		Address <u>Albuquerque New Mexico</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>arterio-sclerotic heart disease</u> (c) <u>generalized arterio-sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> <u>5 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>fracture neck of femur</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 12, 1958</u> to <u>Dec 16, 1958</u> , that I last saw the deceased alive on <u>12/16/58</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. F. Kreuzburg</u>		ADDRESS (Street, city or town, state) <u>7852 16 St. S.W. Wash D.C.</u>	
PHYSICIAN'S NAME (Type) <u>H. F. Kreuzburg</u>		DATE SIGNED <u>12/16/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>SHIP R/R 12-16-58</u>		22b. DATE THEREOF <u>12-16-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>UNION DALE CEM</u>		22d. LOCATION (City, town, or county) <u>PITTSBURGH, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS & Co</u>		24. REC'D BY REGISTRAR <u>DEC 19 '58</u>	
ADDRESS <u>1400 Chapin St. N.W.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

1935

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH	
PLACE OF BIRTH		CITY		COUNTY		STATE		COUNTRY	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		SOCIETY	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED	
DATE OF SIGNATURE		TIME OF SIGNATURE		PLACE OF SIGNATURE		CAUSE OF SIGNATURE		MANNER OF SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13960 CERTIFICATE OF DEATH

13922

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10102 Portland Place		d. STREET ADDRESS 10102 Portland Place	
3. NAME OF DECEASED (Type or print) First Nora Middle Belia Last German		4. DATE OF DEATH Month December Day 29 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/9/79
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 7 Days 9 Hours 17 Min.	IF UNDER 24 HRS. Months 7 Days 9 Hours 17 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? same as #1	
13. FATHER'S NAME James A. Creel		14. MOTHER'S MAIDEN NAME Louise Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, no, or unknown		16. SOCIAL SECURITY NO. same as #1	
17. INFORMANT George W. German		Address same as #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 445X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Malignant Hypertension (c) 17 day		INTERVAL BETWEEN ONSET AND DEATH 17 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema right lung 18 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 22 , 19 40 , to Dec 29 , 19 58 , that I last saw the deceased alive on Dec 28 , 19 58 , and that death occurred at 8:05 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE A Magruder MacDonell M.D.		ADDRESS (Street, city or town, state) 1746 R St NW DC	
DATE SIGNED Dec 29 58		DATE SIGNED Dec 29 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12/31/58	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince George, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company		24a. REC'D BY REGISTRAR DEC 31 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank		24c. REGISTRAR'S SIGNATURE Arthur S. Frank	

1900 CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. PLACE OF BIRTH	
3. SEX		4. AGE	
5. OCCUPATION		6. CAUSE OF DEATH	
7. DATE OF DEATH		8. TIME OF DEATH	
9. NAME OF DECEASED		10. NAME OF ATTENDING PHYSICIAN	
11. NAME OF WITNESS		12. NAME OF REGISTRAR	
13. NAME OF CLERK		14. NAME OF JUDGE	
15. NAME OF SHERIFF		16. NAME OF DEPUTY SHERIFF	
17. NAME OF CORONER		18. NAME OF DEPUTY CORONER	
19. NAME OF JURY		20. NAME OF JURY	
21. NAME OF JURY		22. NAME OF JURY	
23. NAME OF JURY		24. NAME OF JURY	
25. NAME OF JURY		26. NAME OF JURY	
27. NAME OF JURY		28. NAME OF JURY	
29. NAME OF JURY		30. NAME OF JURY	
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33. NAME OF JURY		34. NAME OF JURY	
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45. NAME OF JURY		46. NAME OF JURY	
47. NAME OF JURY		48. NAME OF JURY	
49. NAME OF JURY		50. NAME OF JURY	
51. NAME OF JURY		52. NAME OF JURY	
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59. NAME OF JURY		60. NAME OF JURY	
61. NAME OF JURY		62. NAME OF JURY	
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91. NAME OF JURY		92. NAME OF JURY	
93. NAME OF JURY		94. NAME OF JURY	
95. NAME OF JURY		96. NAME OF JURY	
97. NAME OF JURY		98. NAME OF JURY	
99. NAME OF JURY		100. NAME OF JURY	

THESE RECORDS ARE THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND ARE NOT TO BE LOANED OR REPRODUCED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE COMMISSIONER OF HEALTH.

13870

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calhoun Park</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
f. STREET ADDRESS <u>701 Midland Rd.</u>				g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Eugene Corbin Glasgow</u>				4. DATE OF DEATH <u>12 - 8 - 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/8-98</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Public Relations & Advertising</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Alvah Glasgow</u>				14. MOTHER'S MAIDEN NAME <u>Eulah Corbin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WV-1 & 2 Army & Navy</u>				16. SOCIAL SECURITY NO. <u>473-07-3702</u>		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>204.1 CHRONIC MYELOGENOUS LEUKEMIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>204.1</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PEPTIC ULCER</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY</u> , 19 <u>48</u> , to <u>8 DEC.</u> , 19 <u>58</u> that I last saw the deceased alive on <u>7 DEC.</u> , 19 <u>58</u> , and that death occurred at <u>6:50 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L.B. Snow</u>				ADDRESS (Street, city or town, state) <u>9013 FLOWER AVE, SILVER SPRING, MD.</u> DATE SIGNED <u>12/8/58</u>			
PHYSICIAN'S NAME (Type) <u>L. B. SNOW</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		22b. DATE THEREOF <u>12/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SIOUX FALLS, SOUTH DAKOTA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond D. Ziska</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>DEC 12 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Carling S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13961

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Chesterfield			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 355 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Chester 83x-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Route #3, Box 284			
3. NAME OF DECEASED (Type or print) First Tazzy Middle Otis Last Goad			4. DATE OF DEATH Month December Day 16 Year 1958				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1943		9. AGE (In years last birthday) 15 yrs.	IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min. 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Elmer Otis Goad			14. MOTHER'S MAIDEN NAME Viola Totty				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, nasopharynx, bronchi, lungs 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute lymphocytic Leukemia DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 26, 1957 to December 16, 1958 , that I lost saw the deceased alive on December 16, 1958 , and that death occurred at 4:20 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12-16-58 ACTUAL SIGNATURE Arthur T. Teplitzky M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) Arthur T. Teplitzky, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 18, 1958		22c. NAME OF CEMETERY OR CREMATORY Blandford		22d. LOCATION (City, town, or county) (State) Petersburg Va.	
23. FUNERAL DIRECTOR'S SIGNATURE E. Alvin Small Funeral Home, Inc.				24a. REC'D BY REGISTRAR DATE DEC 31 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13962

CERTIFICATE OF DEATH

13925

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DIST. OF. b. COUNTY COC.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRLAND NURSING HOME			d. STREET ADDRESS 2020-37th St SE		
3. NAME OF DECEASED (Type or print) First WOLF Middle GOLDENTHAL Last GOLDENTHAL			4. DATE OF DEATH Month DEC Day 22 Year 1958		
5. SEX MALE	6. COLOR OF RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-15-89	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUILDER			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ROMANIA
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME ISAAC GOLDENTHAL		
14. MOTHER'S MAIDEN NAME CAROLINE GOLDNER			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		
16. SOCIAL SECURITY NO. (If yes, give year or dates of service)			17. INFORMANT Address ADOLF GOLDENTHAL - 2020-37th St SE, WASH		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Arteriosclerotic Cardiovascular Disease					INTERVAL BETWEEN ONSET AND DEATH 4 mo.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 12-11 , 19 58 , to 12-22 , 19 58 that I last saw the deceased alive on 12-17 , 19 58 , and that death occurred at 11:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2025 - Eye St, NW DATE SIGNED Jerome H. Epstein					
ACTUAL SIGNATURE Jerome H. Epstein M.D. 2025 - Eye St, NW					
PHYSICIAN'S NAME (Type) TEROME H. EPSTEIN, M.D. WASH. 6, D. C.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 24, 1958		22c. NAME OF CEMETERY OR CREMATORY MT. HEBRON CEMETERY	
22d. LOCATION (City, town, or county) (State) FLUSHING - NEW YORK		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS BERNARD DANZANSKY & SONS - 3501-14th St. N.W.			
24a. REC'D BY REGISTRAR DEC 24 '58		24b. REGISTRAR'S SIGNATURE Chickman			

13963 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 2 mons.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ammon's Rest Home		d. STREET ADDRESS 16x-2	
3. NAME OF DECEASED (Type or print) First Mattie Middle Grant Last Grant		4. DATE OF DEATH Month December Day 7 Year 58	
5. SEX fem.	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Unknown	8. DATE OF BIRTH 64
9. AGE (In years last birthday) yrs. 64		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) "U.S.A."		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT W S Washington		Address Wash DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemiplegia DUE TO Cardiorenal Hypertensive Disease (c) INTERVAL BETWEEN ONSET AND DEATH 5 hrs. June 58			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arthritis. Hysteria.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month 12 Day 7 Year 58 a.m. 0 p.m. 0	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 24, 1958 , to Dec. 7, 1958 , that I last saw the deceased alive on Dec. 7, 1958 , and that death occurred at 12:42 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Webster Sewell		ADDRESS (Street, city or town, state) Norbeck Rt. 1 Silver Spring	
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.		DATE SIGNED 12/8	
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-13-58	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Woodlawn	22d. LOCATION (City, town, or county) (State) Washington DC
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington		24a. REC'D BY REGISTRAR DATE DEC 18 '58	24b. REGISTRAR'S SIGNATURE William S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be refiled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
JAMES C. HARRIS		45		M		W		1900		BALTIMORE, MD.		1945		BALTIMORE, MD.	
MARRIAGE		DATE		PLACE		DATE		PLACE		DATE		PLACE		DATE	
MARRIED		1920		BALTIMORE, MD.		1920		BALTIMORE, MD.		1920		BALTIMORE, MD.		1920	
EDUCATION		SCHOOL		CITY		STATE		COUNTRY		DATE		PLACE		DATE	
HIGH SCHOOL		BALTIMORE		MD.		U.S.A.		1920		BALTIMORE, MD.		1920		BALTIMORE, MD.	
OCCUPATION		DATE		PLACE		DATE		PLACE		DATE		PLACE		DATE	
LABORER		1920		BALTIMORE, MD.		1920		BALTIMORE, MD.		1920		BALTIMORE, MD.		1920	
CAUSE OF DEATH		DATE		PLACE		DATE		PLACE		DATE		PLACE		DATE	
HEART DISEASE		1945		BALTIMORE, MD.		1945		BALTIMORE, MD.		1945		BALTIMORE, MD.		1945	
MANNER OF DEATH		DATE		PLACE		DATE		PLACE		DATE		PLACE		DATE	
NATURAL		1945		BALTIMORE, MD.		1945		BALTIMORE, MD.		1945		BALTIMORE, MD.		1945	
CERTIFICATE OF DEATH		DATE		PLACE		DATE		PLACE		DATE		PLACE		DATE	
1945		1945		1945		1945		1945		1945		1945		1945	

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A LICENSED PHYSICIAN OR A LICENSED NURSE. IT IS NOT VALID IF SIGNED BY ANY OTHER PERSON. IT IS NOT VALID IF SIGNED BY A PHYSICIAN OR NURSE WHO IS NOT LICENSED IN THE STATE OF MARYLAND. IT IS NOT VALID IF SIGNED BY A PHYSICIAN OR NURSE WHO IS NOT LICENSED IN THE COUNTY OF BALTIMORE. IT IS NOT VALID IF SIGNED BY A PHYSICIAN OR NURSE WHO IS NOT LICENSED IN THE CITY OF BALTIMORE. IT IS NOT VALID IF SIGNED BY A PHYSICIAN OR NURSE WHO IS NOT LICENSED IN THE DISTRICT OF BALTIMORE. IT IS NOT VALID IF SIGNED BY A PHYSICIAN OR NURSE WHO IS NOT LICENSED IN THE TERRITORY OF BALTIMORE. IT IS NOT VALID IF SIGNED BY A PHYSICIAN OR NURSE WHO IS NOT LICENSED IN THE COUNTY OF BALTIMORE. IT IS NOT VALID IF SIGNED BY A PHYSICIAN OR NURSE WHO IS NOT LICENSED IN THE CITY OF BALTIMORE. IT IS NOT VALID IF SIGNED BY A PHYSICIAN OR NURSE WHO IS NOT LICENSED IN THE DISTRICT OF BALTIMORE. IT IS NOT VALID IF SIGNED BY A PHYSICIAN OR NURSE WHO IS NOT LICENSED IN THE TERRITORY OF BALTIMORE.

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CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF NEXT OF KIN</p>		<p>16. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>17. SIGNATURE OF CHURCH OFFICIAL</p>		<p>18. SIGNATURE OF FUNERAL HOME</p>	
<p>19. SIGNATURE OF CEMETERY OFFICIAL</p>		<p>20. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>21. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>22. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>23. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>24. SIGNATURE OF INTERMENT OFFICIAL</p>	
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<p>99. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>100. SIGNATURE OF INTERMENT OFFICIAL</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13928

13964

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5904 Anniston Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Agnes Marie Antoinette GREEN				4. DATE OF DEATH Month Day Year December 1 19 58			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-14-20	
9. AGE (In years lost birthday) yrs. 38		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown MARCENKO				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service No - - -				16. SOCIAL SECURITY NO. - - -			
17. INFORMANT (H) Wm. J. Green, Same as #2 above				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale with congestive heart failure. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary fibrosis and secondary Emphysema. DUE TO (c) Tuberculosis. INTERVAL BETWEEN ONSET AND DEATH 14 Days.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from November 26, 19 58 , to December 1, 19 58 , that I last saw the deceased alive on December 1, 19 58 , and that death occurred at 2:03 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. J. Jacoby, Jr.				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC			
DATE SIGNED 12-1-58							
PHYSICIAN'S NAME (Type) W. J. JACOBY, JR., LCDR, MC, USN Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-4-58		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Phillipsburg Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS Funeral Home, Bethesda, Md.		24a. REC'D BY REGISTRAR DATE DEC 3 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13965

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10001 Connecticut Avenue				d. STREET ADDRESS 10001 Connecticut Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Anna Middle Rumsey Last Griffith				4. DATE OF DEATH Month 12 Day 30 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-16-1875	
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Months 3 Days 19		IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.		11. BIRTHPLACE (State or foreign country) Kentucky	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME D. Clinton Griffith				14. MOTHER'S MAIDEN NAME Bell Weir			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Harry W. McGinniss -10001 Connecticut Ave Brother-in-law Kensington			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Myocardial degeneration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerotic heart disease				INTERVAL BETWEEN ONSET AND DEATH 24 hours 1 year 3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 12 , 19 53 , to Dec. 30 , 19 58 , that I last saw the deceased alive on Dec. 30 , 19 58 , and that death occurred at 6 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas A. L. Hindman				ADDRESS (Street, city or town, state) 3935 Baltimore St., Kensington, Md.			
PHYSICIAN'S NAME (Type) Thomas A. L. Hindman, 3935 Baltimore St., Kensington, Md.				DATE SIGNED 12/30/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 1-1-59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery		22d. LOCATION (City, town, or county) (State) Owensboro, Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE JAN 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

1900

NAME OF DECEASED MONTGOMERY		SEX MALE		AGE 100		DATE OF BIRTH 1800		PLACE OF BIRTH MONTGOMERY	
RESIDENCE 1000 CONNELL AVE		CITY BALTIMORE		COUNTY BALTIMORE		STATE MD		COUNTRY USA	
DATE OF DEATH 10-20-1900		PLACE OF DEATH HOME		CAUSE OF DEATH OLD AGE		MANNER OF DEATH NATURAL		MEDICAL ATTENDANCE YES	
NAME OF DECEASED MONTGOMERY		SEX MALE		AGE 100		DATE OF BIRTH 1800		PLACE OF BIRTH MONTGOMERY	
RESIDENCE 1000 CONNELL AVE		CITY BALTIMORE		COUNTY BALTIMORE		STATE MD		COUNTRY USA	
DATE OF DEATH 10-20-1900		PLACE OF DEATH HOME		CAUSE OF DEATH OLD AGE		MANNER OF DEATH NATURAL		MEDICAL ATTENDANCE YES	

1000 CONNELL AVE

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD, AND A COPY IS TO BE SENT TO THE LOCAL HEALTH OFFICE IN THE CITY OR TOWN WHERE THE DECEASED RESIDED.

13966

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4818 Cherry Chase Blvd</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Joseph</u> Last <u>Grimberg</u>				4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 9, 1875</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR: Months <u>3</u> Days <u>18</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manufacturing</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Management</u>			
11. BIRTHPLACE (State or foreign country) <u>Germany</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Peter Grimberg</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-33-5664</u>			
17. INFORMANT <u>John C. Grimberg - Son - Same</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Arteriosclerotic Heart Disease</u> (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u></u> Month <u></u> Day <u>19</u> Year <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>46</u> , to <u>Dec</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 27</u> , 19 <u>58</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Leo I Donovan M.D.</u>				M.D. <u>Leo I Donovan M.D.</u> <u>Bethesda, Md</u> <u>12/27/58</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/30/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DEC 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13872 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash San Hosp</u>				d. STREET ADDRESS <u>1108 Wayne Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Meanda</u> First <u>Guiffre</u> Middle <u>Guiffre</u> Last <u>Guiffre</u>				4. DATE OF DEATH <u>Dec 13</u> Month <u>Dec</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 23 1890</u>	9. AGE (In years last birthday) <u>68</u> yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter (Houses) Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Painter</u>		11. BIRTHPLACE (State or foreign country) <u>Wash, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Guiffre</u>			
14. MOTHER'S MAIDEN NAME <u>Josephine Glieden</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>579-69-9107</u>				17. INFORMANT <u>Mrs. Mary Guiffre</u> Address <u>1108 Wayne Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Aneurysm of Aorta with massive hemorrhage Post Pentonatal</u> DUE TO <u>451X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>9 hrs</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>5.5</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov 17</u> , 19 <u>51</u> , to <u>Dec 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 13, 1958</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard T. Morse</u>				ADDRESS (Street, city or town, state) <u>7030 Carroll Ave</u>			
PHYSICIAN'S NAME (Type) <u>Howard T. Morse</u>				DATE SIGNED <u>12/13/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12-13-58

4:00 P.M. - I CALLED DEPUTY
CORONER DR. BROSCART WHO
AUTHORIZED AUTOPSY. THIS IS NOT
A CORONERS CASE.

J. D. Nelson, M.D.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13893

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13932

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 20 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11408 Lux manor Road				d. STREET ADDRESS 11408 Luxmanor Rd.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ESTELLE		First Y. Middle Haller Last		4. DATE OF DEATH Dec. 26		Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1877		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 8 Days 26	IF UNDER 24 HRS. Hours 26 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---Milliner		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Hiram Young				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Daughter Mrs. Walter Roth		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12-29-58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Prince Geo. County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DEC 30 '58	
						24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13967 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE DC b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in home, give street address) OR INSTITUTION 9807 River Road Ropine Nursing Home				d. STREET ADDRESS 3000 Chain Bridge Road			
3. NAME OF DECEASED (Type or print) First William Middle Train Last Halliday				4. DATE OF DEATH Month December Day 28 Year 19 58			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/12/1886	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Banker-President				10b. KIND OF BUSINESS OR INDUSTRY 1st Natl. Bk. Arlington, Va.		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME William Henry Halliday				14. MOTHER'S MAIDEN NAME Emma Jane Trimble			
15. WAS DECEASED EVER IN U. S. ARMY FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Nursing Home Records-9807 River Road Bethesda, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cerebro-Vascular Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 24 Dec , 19 58 , to 28 Dec , 19 58 , that I last saw the deceased alive on 26 Dec , 19 58 , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. F. Cresswell, Jr.				ADDRESS (Street, city or town, state) 9902 Connell Rd Bethesda 14 Maryland			
PHYSICIAN'S NAME (Type)				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/30/58		22c. NAME OF CEMETERY OR CREMATORY --		22d. LOCATION (City, town, or county) (State) Newton, Massachusetts	
23. FUNERAL DIRECTOR'S SIGNATURE Sta S. H. Hine Co.				ADDRESS 2901-4th St. N.W.		24a. REC'D BY REGISTRAR DATE DEC 31 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hine			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1906

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1906

REG. NO. 10

NAME OF DECEASED JOHN DOE		SEX Male		AGE 35		DATE OF BIRTH Jan 1, 1871		PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk		MARITAL STATUS Single		COLOR White	
RESIDENCE 1234 Main St. Baltimore, Md.		DECEASED AT 1234 Main St. Baltimore, Md.		DATE OF DEATH Dec 15, 1906		TIME OF DEATH 10:30 AM		PLACE OF DEATH 1234 Main St. Baltimore, Md.		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		MEDICAL ATTENDANT Dr. J. H. Smith	
SIGNATURE OF DECEASED John Doe		SIGNATURE OF NEXT OF KIN Jane Doe		SIGNATURE OF MEDICAL ATTENDANT Dr. J. H. Smith		SIGNATURE OF REGISTRAR J. H. Doe		SIGNATURE OF CLERK J. H. Doe		SIGNATURE OF JURY J. H. Doe		SIGNATURE OF JURY J. H. Doe		SIGNATURE OF JURY J. H. Doe	
CERTIFICATE OF DEATH This is to certify that the above named person died on the 15th day of December, 1906, at the residence of the deceased, 1234 Main St., Baltimore, Md., of Heart Disease, a natural cause.		CERTIFICATE OF DEATH This is to certify that the above named person died on the 15th day of December, 1906, at the residence of the deceased, 1234 Main St., Baltimore, Md., of Heart Disease, a natural cause.		CERTIFICATE OF DEATH This is to certify that the above named person died on the 15th day of December, 1906, at the residence of the deceased, 1234 Main St., Baltimore, Md., of Heart Disease, a natural cause.		CERTIFICATE OF DEATH This is to certify that the above named person died on the 15th day of December, 1906, at the residence of the deceased, 1234 Main St., Baltimore, Md., of Heart Disease, a natural cause.		CERTIFICATE OF DEATH This is to certify that the above named person died on the 15th day of December, 1906, at the residence of the deceased, 1234 Main St., Baltimore, Md., of Heart Disease, a natural cause.		CERTIFICATE OF DEATH This is to certify that the above named person died on the 15th day of December, 1906, at the residence of the deceased, 1234 Main St., Baltimore, Md., of Heart Disease, a natural cause.		CERTIFICATE OF DEATH This is to certify that the above named person died on the 15th day of December, 1906, at the residence of the deceased, 1234 Main St., Baltimore, Md., of Heart Disease, a natural cause.		CERTIFICATE OF DEATH This is to certify that the above named person died on the 15th day of December, 1906, at the residence of the deceased, 1234 Main St., Baltimore, Md., of Heart Disease, a natural cause.	

13968

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 1824 15th Street, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Louis Middle Alexander Last HAMNER				4. DATE OF DEATH Month December Day 9 Year 19 58			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-10-96	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 9 Days 19 Hours 58 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		11. BIRTHPLACE (State or foreign country) Montana	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas J. HAMNER		14. MOTHER'S MAIDEN NAME Louise LUCAS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 3/25 to 2/28	
16. SOCIAL SECURITY NO. 579-18-8340		17. INFORMANT (W) Mrs. Georgia A. Hamner, same as #2 above		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSION AND CHRONIC PYELONEPHRITIS (c) PULMONARY FIBROSIS 20 TO EMPYEMA INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES 10 MONTHS 11 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from December 5, 1958 , to December 9, 1958 , that I last saw the deceased alive on December 9, 1958 , and that death occurred at 10:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC DATE SIGNED 12-10-58							
ACTUAL SIGNATURE James M. Young M.D.				PHYSICIAN'S NAME (Type) James M. Young, LT, MC, USN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-15-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) Arlington				(State) Virginia		23. FUNERAL DIRECTOR'S SIGNATURE Campbell Funeral Home, 522 8th St., SE, Washington D.C.	
24a. REC'D BY REGISTRAR REC 15 '58				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

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2013

2. V. 2. 52

13969

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>13x-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp</u>				d. STREET ADDRESS <u>Clarksville, Md</u>			
3. NAME OF DECEASED (Type or print) <u>Baby Boy HARDING</u>				4. DATE OF DEATH Month <u>December</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>CR</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/12/58</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Carroll C. Harding</u>				14. MOTHER'S MAIDEN NAME <u>Shirley K. Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mother Mrs Shirley Harding Clarksville Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>central placenta previa</u> <u>761.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> and that death occurred at <u>7:31</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Michael L Buckley</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/19/58</u>		<u>Hopkins Chapel</u>		<u>Near Clarksville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ridgely Kelly 1200 Snowden Place</u> <u>Stamford Md</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 22 '58</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074223XV4

CERTIFICATE OF DEATH

18802

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

See Part No. 1

<p>1. Name of deceased: <u>John Doe</u></p>	
<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>	
<p>4. Date of death: <u>Jan 15, 1910</u></p>	
<p>5. Place of death: <u>Home</u></p>	
<p>6. Cause of death: <u>Heart Disease</u></p>	
<p>7. Signature of physician: <u>Dr. J. Smith</u></p>	
<p>8. Signature of registrar: <u>John Doe</u></p>	
<p>9. Signature of witness: <u>John Doe</u></p>	
<p>10. Signature of witness: <u>John Doe</u></p>	
<p>11. Signature of witness: <u>John Doe</u></p>	
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<p>99. Signature of witness: <u>John Doe</u></p>	
<p>100. Signature of witness: <u>John Doe</u></p>	

REGISTRATION

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THE INFORMATION CONTAINED HEREIN IS CORRECT AND COMPLETE. ANY FALSIFICATION OR MISREPRESENTATION OF THE INFORMATION CONTAINED HEREIN IS A CRIME UNDER THE LAWS OF THE STATE OF MARYLAND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13936

13970

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Rest Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rose Middle Marie Last Harkins		4. DATE OF DEATH Month Dec. Day 21 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1870
9. AGE (In years last birthday) yrs. 88		IF UNDER 1 YEAR Months 3 Days 15 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S	
13. FATHER'S NAME Joseph Brenner		14. MOTHER'S MAIDEN NAME Elizabeth Shubert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. W. E. Mullan-daughter-same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary thrombosis, acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c) Advanced Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 hours 10 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Very advanced rheumatoid arthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 to Dec 21, 1958 , that I last saw the deceased alive on Dec 17, 1958 , and that death occurred at 6:00 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3921 Ingomar St N.W. Wash 15 D.C. DATE SIGNED Dec 21 1958			
ACTUAL SIGNATURE Stewart Clapp		M.D. 3921 Ingomar St N.W. Dec 21 1958	
PHYSICIAN'S NAME (Type) Stewart Clapp		Wash 15 D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/24/58	22c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DEC 24 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

13971 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>1212 Allison Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JACK E HAWKINS</u>		First Middle Last		4. DATE OF DEATH <u>December 7 1958</u>		Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 23, 1927</u>		9. AGE (In years last birthday) <u>31 yrs.</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>14</u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheetmetal Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmac Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Edison C. Hawkins</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lou Hutton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW Korean</u>		16. SOCIAL SECURITY NO. <u>216-22-2179</u>		17. INFORMANT <u>Margaret W. Hawkins-wife-same as 2d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inter-cerebral hemorrhage</u> <u>33/x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Unknown</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found unconscious on floor of home 11/25/58</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>12/8/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-9-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey, Rockville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

13972

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Northumberland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burgess 83X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Memor Nursing Home				d. STREET ADDRESS Burgess			
3. NAME OF DECEASED (Type or print) First PRISCILLA Middle HAYDEN Last HAYDEN				4. DATE OF DEATH Month DEC. Day 18, Year 1958			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1865	9. AGE (In years last birthday) 93 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA -	
13. FATHER'S NAME Septimus Headley				14. MOTHER'S M maiden NAME Ann Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —		17. INFORMANT Address Mrs. A. H. Jones Rainwood Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic Heart Dis. (c) Senility						INTERVAL BETWEEN ONSET AND DEATH 7 months 5 + yr. 5 + yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1 Jan 57 to 18 DEC 1958 , that I last saw the deceased alive on 13 DEC 1958 , and that death occurred at 9 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5522 Woodman Rd DATE SIGNED 18 DEC 1958 ACTUAL SIGNATURE A. H. Richwine M.D. PHYSICIAN'S NAME (Type) A. H. RICHWINE, MD Chem Chase 15, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 14/20/58		22c. NAME OF CEMETERY OR CREMATORY Fairfields		22d. LOCATION (City, town, or county) (State) Burgess VA	
23. FUNERAL DIRECTOR'S SIGNATURE John Lee & Sons ADDRESS 300 H St NE Wash DC				24a. REC'D BY REGISTRAR DEC 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES M. SMITH		2. SEX MALE		3. AGE 65	
4. DATE OF DEATH JAN 15 1968		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH HOME	
7. CAUSE OF DEATH CORONARY HEART DISEASE		8. MANNER OF DEATH NATURAL		9. MEDICAL HISTORY HYPERTENSION	
10. SIGNATURE OF PHYSICIAN J. M. SMITH		11. SIGNATURE OF WITNESS J. M. SMITH		12. SIGNATURE OF DECEASED J. M. SMITH	
13. SIGNATURE OF DECEASED J. M. SMITH		14. SIGNATURE OF DECEASED J. M. SMITH		15. SIGNATURE OF DECEASED J. M. SMITH	
16. SIGNATURE OF DECEASED J. M. SMITH		17. SIGNATURE OF DECEASED J. M. SMITH		18. SIGNATURE OF DECEASED J. M. SMITH	
19. SIGNATURE OF DECEASED J. M. SMITH		20. SIGNATURE OF DECEASED J. M. SMITH		21. SIGNATURE OF DECEASED J. M. SMITH	
22. SIGNATURE OF DECEASED J. M. SMITH		23. SIGNATURE OF DECEASED J. M. SMITH		24. SIGNATURE OF DECEASED J. M. SMITH	
25. SIGNATURE OF DECEASED J. M. SMITH		26. SIGNATURE OF DECEASED J. M. SMITH		27. SIGNATURE OF DECEASED J. M. SMITH	
28. SIGNATURE OF DECEASED J. M. SMITH		29. SIGNATURE OF DECEASED J. M. SMITH		30. SIGNATURE OF DECEASED J. M. SMITH	
31. SIGNATURE OF DECEASED J. M. SMITH		32. SIGNATURE OF DECEASED J. M. SMITH		33. SIGNATURE OF DECEASED J. M. SMITH	
34. SIGNATURE OF DECEASED J. M. SMITH		35. SIGNATURE OF DECEASED J. M. SMITH		36. SIGNATURE OF DECEASED J. M. SMITH	
37. SIGNATURE OF DECEASED J. M. SMITH		38. SIGNATURE OF DECEASED J. M. SMITH		39. SIGNATURE OF DECEASED J. M. SMITH	
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52. SIGNATURE OF DECEASED J. M. SMITH		53. SIGNATURE OF DECEASED J. M. SMITH		54. SIGNATURE OF DECEASED J. M. SMITH	
55. SIGNATURE OF DECEASED J. M. SMITH		56. SIGNATURE OF DECEASED J. M. SMITH		57. SIGNATURE OF DECEASED J. M. SMITH	
58. SIGNATURE OF DECEASED J. M. SMITH		59. SIGNATURE OF DECEASED J. M. SMITH		60. SIGNATURE OF DECEASED J. M. SMITH	
61. SIGNATURE OF DECEASED J. M. SMITH		62. SIGNATURE OF DECEASED J. M. SMITH		63. SIGNATURE OF DECEASED J. M. SMITH	
64. SIGNATURE OF DECEASED J. M. SMITH		65. SIGNATURE OF DECEASED J. M. SMITH		66. SIGNATURE OF DECEASED J. M. SMITH	
67. SIGNATURE OF DECEASED J. M. SMITH		68. SIGNATURE OF DECEASED J. M. SMITH		69. SIGNATURE OF DECEASED J. M. SMITH	
70. SIGNATURE OF DECEASED J. M. SMITH		71. SIGNATURE OF DECEASED J. M. SMITH		72. SIGNATURE OF DECEASED J. M. SMITH	
73. SIGNATURE OF DECEASED J. M. SMITH		74. SIGNATURE OF DECEASED J. M. SMITH		75. SIGNATURE OF DECEASED J. M. SMITH	
76. SIGNATURE OF DECEASED J. M. SMITH		77. SIGNATURE OF DECEASED J. M. SMITH		78. SIGNATURE OF DECEASED J. M. SMITH	
79. SIGNATURE OF DECEASED J. M. SMITH		80. SIGNATURE OF DECEASED J. M. SMITH		81. SIGNATURE OF DECEASED J. M. SMITH	
82. SIGNATURE OF DECEASED J. M. SMITH		83. SIGNATURE OF DECEASED J. M. SMITH		84. SIGNATURE OF DECEASED J. M. SMITH	
85. SIGNATURE OF DECEASED J. M. SMITH		86. SIGNATURE OF DECEASED J. M. SMITH		87. SIGNATURE OF DECEASED J. M. SMITH	
88. SIGNATURE OF DECEASED J. M. SMITH		89. SIGNATURE OF DECEASED J. M. SMITH		90. SIGNATURE OF DECEASED J. M. SMITH	
91. SIGNATURE OF DECEASED J. M. SMITH		92. SIGNATURE OF DECEASED J. M. SMITH		93. SIGNATURE OF DECEASED J. M. SMITH	
94. SIGNATURE OF DECEASED J. M. SMITH		95. SIGNATURE OF DECEASED J. M. SMITH		96. SIGNATURE OF DECEASED J. M. SMITH	
97. SIGNATURE OF DECEASED J. M. SMITH		98. SIGNATURE OF DECEASED J. M. SMITH		99. SIGNATURE OF DECEASED J. M. SMITH	
100. SIGNATURE OF DECEASED J. M. SMITH		101. SIGNATURE OF DECEASED J. M. SMITH		102. SIGNATURE OF DECEASED J. M. SMITH	

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN OR A NOTARY PUBLIC.

FOR FURTHER INFORMATION, SEE THE INSTRUCTIONS ON THE REVERSE SIDE OF THIS CERTIFICATE.

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN OR A NOTARY PUBLIC.

FOR FURTHER INFORMATION, SEE THE INSTRUCTIONS ON THE REVERSE SIDE OF THIS CERTIFICATE.

13973

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE District of Columbia c. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 87 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 3901 Connecticut Ave., N.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Paule Middle Vincent Last HELLWEG				4. DATE OF DEATH Month December Day 15 Year 1958			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-7-81	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) France	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henri VINCENT				14. MOTHER'S MAIDEN NAME Elizabeth CRIMMINS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (H) Fredrick Hellweg, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular degeneration 334x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cerebrovascular disease DUE TO (c) recurrent Arteriosclerotic heart disease, chronic pyelonephritis, pneumonitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 492x recurrent Arteriosclerotic heart disease, chronic pyelonephritis, pneumonitis				INTERVAL BETWEEN ONSET AND DEATH 5-6 yrs 5-6 yrs			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from September 19, 1958 , to December 15, 1958 , that I last saw the deceased alive on December 15, 1958 , and that death occurred at 2:05A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John Wood Davis				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC			
DATE SIGNED 12-15-58							
PHYSICIAN'S NAME (Type) J. W. DAVIS, I.T. MC, USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-18-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Jos. Gawler's & Sons				ADDRESS 1756 Penn. Ave, NW, Wash.D.C.		24a. REC'D BY REGISTRAR DEC 18 '58	
24b. REGISTRAR'S SIGNATURE Arthur B. Frawley							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13894 CERTIFICATE OF DEATH

13940

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2646 Rockville Avenue, Gaithersburg, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>908 Viers Mill Road</u>				d. STREET ADDRESS <u>1304 Great Falls Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROBERTA</u> Middle <u>P</u> Last <u>HIGGINS</u>				4. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 26, 1886</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>10</u>		IF UNDER 24 HRS. Hours <u>10</u> Min. <u>15</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>US Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>Frank Higgins</u>				14. MOTHER'S MAIDEN NAME <u>Roberta Baker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Frank Wilson-6 Maryland Ave. Gaithersburg</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>8 years</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June, 1953</u> , to <u>12-6-58</u> , that I last saw the deceased alive on <u>12-3-58</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. G. Hall</u> M.D. <u>615 W. Montgomery Ave. Rockville, Md</u>				DATE SIGNED <u>12-6-58</u>			
PHYSICIAN'S NAME (Type) <u>W. G. Hall</u>				<u>615 W. Montgomery Ave. Rockville, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DEC 10 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED		2. PLACE OF DEATH	
3. SEX		4. AGE	
5. DATE OF BIRTH		6. DATE OF DEATH	
7. TIME OF DEATH		8. PLACE OF BIRTH	
9. OCCUPATION		10. CAUSE OF DEATH	
11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS	
15. SIGNATURE OF DECEASED		16. SIGNATURE OF NEXT OF KIN	
17. SIGNATURE OF CLERGYMAN		18. SIGNATURE OF BURIAL OFFICIAL	
19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF CEMETERY	
21. SIGNATURE OF CHURCH		22. SIGNATURE OF MONASTERY	
23. SIGNATURE OF HOSPITAL		24. SIGNATURE OF NURSING HOME	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER	
27. SIGNATURE OF OTHER		28. SIGNATURE OF OTHER	
29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER	
33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER	
35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER	
39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER	
41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
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91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER	
93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER	
95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER	
99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	

13974 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 5204 Goddard Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELIZABETH THOMAS HILL		4. DATE OF DEATH Dec. 29, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1873
9. AGE (In years last birthday) 85		IF UNDER 1 YEAR Months 9 Days 8	
IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Hugh R. Greene		14. MOTHER'S MAIDEN NAME Katherine Seattle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Robert G. Hill-Item#2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease - acute 420.0 DUE TO pulmonary edema. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Seriousity DUE TO Viol. Gastr. intestinal Disease (c) 		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 Month, Day, Year p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 11, 1953 , to Dec 29, 1958 , that I last saw the deceased alive on 12/25/1958 , and that death occurred at 1 A. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. T. Joyce		ADDRESS (Street, city or town, state) Bethesda, Md.	
DATE SIGNED 12/29/58			
PHYSICIAN'S NAME (Type) W. T. Joyce		8106 Maple Ridge, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL, OR DISPOSITION Burial Transit		22b. DATE THEREOF 1/1/59	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. [Signature]		24a. REC'D BY REGISTRAR Bethesda, Md.	
24b. REGISTRAR'S SIGNATURE [Signature]		DATE DEC 30 1958	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13975

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Rockville		c. LENGTH OF STAY IN 1b x RFD Rockville		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SARAH C. HINTON		First SARAH		Middle C. HINTON		Last 		4. DATE OF DEATH Month December Day 5 Year 1958 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 27, 1879		9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months 9 Days 8 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME George Cornwell		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Theodore Hinton-Item# 2		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute left ventricular failure (c) Arteriosclerotic hypertensive cardiac vascular disease		INTERVAL BETWEEN ONSET AND DEATH few days 10 years		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I attended the deceased from about 1940 , to Dec 5, 1958 , that I last saw the deceased alive on Dec 4, 1958 , and that death occurred at 130 AM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 26 N. Summit Hwy.		DATE SIGNED 12/5/58		ACTUAL SIGNATURE Wm A. Linthicum		M.D. 		PHYSICIAN'S NAME (Type) Wm A. Linthicum - J. Linthicum, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/8/58		22c. NAME OF CEMETERY OR CREMATORY Darnestown Ch. Cem.		22d. LOCATION (City, town, or county) (State) Darnestown, Md.		24a. REC'D BY REGISTRAR DATE 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda-Md.		ADDRESS 		24a. REC'D BY REGISTRAR DATE 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hines					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BANNING ONE 10

1915

<p>1. Name of deceased: <u>ROBERT A. MCGEE</u></p>		<p>2. Date of death: <u>1915</u></p>	
<p>3. Place of death: <u>At home</u></p>		<p>4. Cause of death: <u>Heart disease</u></p>	
<p>5. Age at death: <u>65</u></p>		<p>6. Sex: <u>Male</u></p>	
<p>7. Race: <u>White</u></p>		<p>8. Marital status: <u>Married</u></p>	
<p>9. Occupation: <u>Farmer</u></p>		<p>10. Residence: <u>123 Main St., Baltimore, Md.</u></p>	
<p>11. Name of physician: <u>Dr. J. H. Smith</u></p>		<p>12. Name of undertaker: <u>John Doe</u></p>	
<p>13. Name of funeral home: <u>None</u></p>		<p>14. Name of cemetery: <u>Greenwood</u></p>	
<p>15. Name of burial place: <u>Section 1, Lot 10</u></p>		<p>16. Name of interment: <u>Interment</u></p>	
<p>17. Name of registrar: <u>John Doe</u></p>		<p>18. Name of registrar: <u>John Doe</u></p>	
<p>19. Name of registrar: <u>John Doe</u></p>		<p>20. Name of registrar: <u>John Doe</u></p>	
<p>21. Name of registrar: <u>John Doe</u></p>		<p>22. Name of registrar: <u>John Doe</u></p>	
<p>23. Name of registrar: <u>John Doe</u></p>		<p>24. Name of registrar: <u>John Doe</u></p>	
<p>25. Name of registrar: <u>John Doe</u></p>		<p>26. Name of registrar: <u>John Doe</u></p>	
<p>27. Name of registrar: <u>John Doe</u></p>		<p>28. Name of registrar: <u>John Doe</u></p>	
<p>29. Name of registrar: <u>John Doe</u></p>		<p>30. Name of registrar: <u>John Doe</u></p>	
<p>31. Name of registrar: <u>John Doe</u></p>		<p>32. Name of registrar: <u>John Doe</u></p>	
<p>33. Name of registrar: <u>John Doe</u></p>		<p>34. Name of registrar: <u>John Doe</u></p>	
<p>35. Name of registrar: <u>John Doe</u></p>		<p>36. Name of registrar: <u>John Doe</u></p>	
<p>37. Name of registrar: <u>John Doe</u></p>		<p>38. Name of registrar: <u>John Doe</u></p>	
<p>39. Name of registrar: <u>John Doe</u></p>		<p>40. Name of registrar: <u>John Doe</u></p>	
<p>41. Name of registrar: <u>John Doe</u></p>		<p>42. Name of registrar: <u>John Doe</u></p>	
<p>43. Name of registrar: <u>John Doe</u></p>		<p>44. Name of registrar: <u>John Doe</u></p>	
<p>45. Name of registrar: <u>John Doe</u></p>		<p>46. Name of registrar: <u>John Doe</u></p>	
<p>47. Name of registrar: <u>John Doe</u></p>		<p>48. Name of registrar: <u>John Doe</u></p>	
<p>49. Name of registrar: <u>John Doe</u></p>		<p>50. Name of registrar: <u>John Doe</u></p>	
<p>51. Name of registrar: <u>John Doe</u></p>		<p>52. Name of registrar: <u>John Doe</u></p>	
<p>53. Name of registrar: <u>John Doe</u></p>		<p>54. Name of registrar: <u>John Doe</u></p>	
<p>55. Name of registrar: <u>John Doe</u></p>		<p>56. Name of registrar: <u>John Doe</u></p>	
<p>57. Name of registrar: <u>John Doe</u></p>		<p>58. Name of registrar: <u>John Doe</u></p>	
<p>59. Name of registrar: <u>John Doe</u></p>		<p>60. Name of registrar: <u>John Doe</u></p>	
<p>61. Name of registrar: <u>John Doe</u></p>		<p>62. Name of registrar: <u>John Doe</u></p>	
<p>63. Name of registrar: <u>John Doe</u></p>		<p>64. Name of registrar: <u>John Doe</u></p>	
<p>65. Name of registrar: <u>John Doe</u></p>		<p>66. Name of registrar: <u>John Doe</u></p>	
<p>67. Name of registrar: <u>John Doe</u></p>		<p>68. Name of registrar: <u>John Doe</u></p>	
<p>69. Name of registrar: <u>John Doe</u></p>		<p>70. Name of registrar: <u>John Doe</u></p>	
<p>71. Name of registrar: <u>John Doe</u></p>		<p>72. Name of registrar: <u>John Doe</u></p>	
<p>73. Name of registrar: <u>John Doe</u></p>		<p>74. Name of registrar: <u>John Doe</u></p>	
<p>75. Name of registrar: <u>John Doe</u></p>		<p>76. Name of registrar: <u>John Doe</u></p>	
<p>77. Name of registrar: <u>John Doe</u></p>		<p>78. Name of registrar: <u>John Doe</u></p>	
<p>79. Name of registrar: <u>John Doe</u></p>		<p>80. Name of registrar: <u>John Doe</u></p>	
<p>81. Name of registrar: <u>John Doe</u></p>		<p>82. Name of registrar: <u>John Doe</u></p>	
<p>83. Name of registrar: <u>John Doe</u></p>		<p>84. Name of registrar: <u>John Doe</u></p>	
<p>85. Name of registrar: <u>John Doe</u></p>		<p>86. Name of registrar: <u>John Doe</u></p>	
<p>87. Name of registrar: <u>John Doe</u></p>		<p>88. Name of registrar: <u>John Doe</u></p>	
<p>89. Name of registrar: <u>John Doe</u></p>		<p>90. Name of registrar: <u>John Doe</u></p>	
<p>91. Name of registrar: <u>John Doe</u></p>		<p>92. Name of registrar: <u>John Doe</u></p>	
<p>93. Name of registrar: <u>John Doe</u></p>		<p>94. Name of registrar: <u>John Doe</u></p>	
<p>95. Name of registrar: <u>John Doe</u></p>		<p>96. Name of registrar: <u>John Doe</u></p>	
<p>97. Name of registrar: <u>John Doe</u></p>		<p>98. Name of registrar: <u>John Doe</u></p>	
<p>99. Name of registrar: <u>John Doe</u></p>		<p>100. Name of registrar: <u>John Doe</u></p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13976

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13943

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus		c. LENGTH OF STAY IN 1b 7 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9721 Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eddie Hodges		4. DATE OF DEATH Month 12 Day 13 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/18/92
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter Hodges		14. MOTHER'S MAIDEN NAME Eliza Atkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) No		16. SOCIAL SECURITY NO. 228609-4627	
17. INFORMANT Wm. E. Hodges, Damascus, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Found dead on floor of home			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 16, 1958	
22c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon		22d. LOCATION (City, town, or county) (State) Nr. Damascus, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Moleman		24a. REC'D BY REGISTRAR DATE DEC 19 '58	
ADDRESS Damascus, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2376

DATE

SEX OF DECEASED

DATE OF BIRTH

AGE

NAME OF DECEASED

LABORING

TIME

PLACE

DATE OF DEATH

TIME

DECEASED

DECEASED

DECEASED

SEX

DECEASED

DECEASED

DECEASED

DATE

DECEASED

DECEASED

226-4-422 Mr. J. Hodges, Jr. Anne, Md.

Obituary notation

Obituary notation

Obituary notation

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13977

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 92 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi d. STREET ADDRESS 10117 Riggs Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Paula Middle Thekle Last Hohenner				4. DATE OF DEATH Month December Day 8 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 21, 1908	
9. AGE (In years last birthday) 50 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Unascertainable		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Benedict Heiss			
14. MOTHER'S MAIDEN NAME Thekle Haeffner				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) hepatic failure 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic carcinoma of breast DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 4 wks 3 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from September 7, 1958 , to December 8, 1958 , that I last saw the deceased alive on December 8, 1958 , and that death occurred at 2:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Richard H. Moy M.D. The Clinical Center 12-2-58 PHYSICIAN'S NAME (Type) Richard H. Moy, M. D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-11-58		22c. NAME OF CEMETERY OR CREMATORY Wash. Mem. Park		22d. LOCATION (City, town, or county) (State) Hyattsville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers ADDRESS 1400 Chapin St. N.W.				24a. REC'D BY REGISTRAR DATE DEC 12 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13945

13873 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Sen. & Hosp.</u>				d. STREET ADDRESS <u>1504 Stirling Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas</u> First <u>Humphrey</u> Middle <u>—</u> Last				4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-17-70</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Humphrey</u>				14. MOTHER'S MAIDEN NAME <u>Rose —</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Walter Humphrey (son)</u> Address <u>(same)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <u>Dec. 10</u> , 19 <u>58</u> , to <u>Dec. 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec. 20</u> , 19 <u>58</u> , and that death occurred at <u>10:05</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr., M.D.</u>		ADDRESS (Street, city or town, state) <u>9301 Colesville Rd., Silver Spring, Md.</u>					
DATE SIGNED <u>Dec. 20 '58</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, or other disposition <u>—</u>		22b. DATE THEREOF <u>12/22/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Fines Co., 2901 14th St. N.W.,</u>				ADDRESS <u>Wash, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 24 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13874

CERTIFICATE OF DEATH

13946

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>10 1/2 hrs.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp.</u>				d. STREET ADDRESS <u>168 Fleetwood Terrace</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Peter</u> Last <u>Hunt</u>				4. DATE OF DEATH Month <u>12</u> Day <u>-</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-22-11</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dental Tech.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Frank Hunt</u>				14. MOTHER'S MAIDEN NAME <u>Margaretta Hayes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW2</u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Wife & Chart</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Cardiac Failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Disease-occlusion</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs.</u> <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Overweight.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec 4, 1958</u> , to <u>Dec 5, 1958</u> , that I last saw the deceased alive on <u>Dec 5, 1958</u> , and that death occurred at <u>10:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u>				ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>				DATE SIGNED <u>12/5/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Maryland</u>		24a. REC'D BY REGISTRAR <u>DEC 9 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**
13978 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13947

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b X Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8001 Kerry Lane		d. STREET ADDRESS 8001 Kerry Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN First L. Middle HUNTINGTON Last		4. DATE OF DEATH Dec. 1, Month 19 Day 58 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1900
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 5 Days 1 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Industrial Consultant		10b. KIND OF BUSINESS OR INDUSTRY Indiana	
11. BIRTHPLACE (State or foreign country) US		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Oscar Huntington		14. MOTHER'S MAIDEN NAME Barbara Jane Richardson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WW I		16. SOCIAL SECURITY NO. Res. unknown 216-38-5364	
17. INFORMANT Ruth H. Huntington-Item# 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 12.1/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/3/58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DEC 5 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13895

CERTIFICATE OF DEATH

13948

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1119-Clagett Dr. Rockville, Md				c. LENGTH OF STAY IN 1b 6 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				/d. STREET ADDRESS Beallsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Eugene Last Hurt				4. DATE OF DEATH Month December Day 21 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25 -1894		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 21 Days 21 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Montg. Co. Md Employee		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John S. Hurt				14. MOTHER'S MAIDEN NAME Emma Lambert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes 1914-1918		16. SOCIAL SECURITY NO. 577-26-7938		17. INFORMANT Mrs Eugene Hurt, 1119-Clagett Dr. Rockville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE FROM ESOPHAGEAL VARICES 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CIRRHOSIS OF LIVER DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 10 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE 20 19 58 , to DECEMBER 21 19 58 , that I last saw the deceased alive on DECEMBER 20 , 19 58 , and that death occurred at 4:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 544 W MONTGOMERY AVE ROCKVILLE MD DATE SIGNED 12/21/58 ACTUAL SIGNATURE William T. Frank PHYSICIAN'S NAME (Type) William T. Frank, M.D. 544 W MONTGOMERY AVE ROCKVILLE MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/58		22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Beallsville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton Barnesville Md				24a. REC'D BY REGISTRAR DEC 29 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13979

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN lb 3 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Brookeville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital, Inc.				d. STREET ADDRESS ROUTE #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Warren Vivian Jack				4. DATE OF DEATH Month Day Year 12- 7 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-3-04	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Andrew J. Jack				14. MOTHER'S MAIDEN NAME Sally Zimbrow			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-12-8345		17. INFORMANT Address Bertha Jack same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion - Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 hours 7 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March , 19 58 , to Dec 7 , 19 58 , that I last saw the deceased alive on Dec 7 , 19 58 , and that death occurred at 4:12 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 12/7/58							
ACTUAL SIGNATURE Richard A. Yates M.D.							
PHYSICIAN'S NAME (Type) Richard A. Yates, M.D.				Olney, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/10/58		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WERNER E. PUMPHREY, INC. Raymond A. Gurtka				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DEC 15 '58	
				24b. REGISTRAR'S SIGNATURE Charles E. Moore			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13950

13980

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery County		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 1314 "K" Street, SE	
3. NAME OF DECEASED (Type or print) Brevard Curtis JACKSON		4. DATE OF DEATH Month December Day 23 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 July 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Boiler Work	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John BREVARD JACKSON		14. MOTHER'S MAIDEN NAME Sally CULBERSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 243 12 7983	
17. INFORMANT Mrs. Annie JACKSON, 1314 K St., S.E., Wash., D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebular vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Two hours Two years			INTERVAL BETWEEN ONSET AND DEATH Two hours Two years
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. BROSCHART		DATE SIGNED 12/23/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-29-58	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE W. E. JARVIS, Funeral Home 1432 U St., NW, WDC		24a. REC'D BY REGISTRAR DATE DEC 29 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Usual residence: _____
7. Date of death: _____
8. Time of death: _____
9. Place of death: _____
10. Cause of death: _____
11. Manner of death: _____
12. Signature of medical examiner: _____
13. Title of medical examiner: _____
14. Date of examination: _____

15. Signature of physician: _____
16. Title of physician: _____
17. Date of examination: _____
18. Signature of coroner: _____
19. Title of coroner: _____
20. Date of examination: _____
21. Signature of registrar: _____
22. Title of registrar: _____
23. Date of examination: _____
24. Signature of clerk: _____
25. Title of clerk: _____
26. Date of examination: _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13951

13981

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Monty Co Gen Hosp</u>			e. STREET ADDRESS <u>mt zim Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Carolyn Lee Jackson</u>			4. DATE OF DEATH <u>12-12-1958</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>2-22-58</u>		9. AGE (In years last birthday) <u>9</u> yrs. <u>12</u> months <u>12</u> days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>md</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Lilburn Jackson</u>			14. MOTHER'S MAIDEN NAME <u>Shirley Lee Jackson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <u>##</u>		
17. INFORMANT <u>Shirley Jackson</u>			Address <u>Olney 2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Trauma - Burectasis</u> <u>500X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Found collapsed in bed</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Involved in auto accident 11-4-58 with moderate concussion</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>11-4-58</u> Hour <u>11:45</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>highway</u>	
20f. (City or town) <u>mt zim</u> (County) <u>monty</u> (State) <u>md</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-12-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 17 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Seals Farm</u>	
22d. LOCATION (City, town, or county) <u>Etchison</u>		(State) <u>md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W. Barber</u>		ADDRESS <u>Laytonsville, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 19 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>					

2023182XV5

FOR STATE
HEALTH USE

1981

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1981

Form with multiple sections for medical examination, including fields for patient information, medical history, and examination findings. The form is oriented vertically on the page.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13982

CERTIFICATE OF DEATH

13952

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 16 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville d. STREET ADDRESS - - - - e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mark Pulliam JEFFERS		4. DATE OF DEATH Month Day Year December 12 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-23-95
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Benton JEFFERS		14. MOTHER'S MAIDEN NAME Glovinia DEACINS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 6/18 - 9/18	
17. INFORMANT (W) Mrs. Julia E. Jeffers, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of Myocardium DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420.1 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 26, 19 58 to December 12, 19 58 , that I last saw the deceased alive on December 12, 19 58 , and that death occurred at 10:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NMHC 12-12-58			
ACTUAL SIGNATURE R. G. MUTH, LT, MC, USN		M.D. Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-15-58	
22c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		22d. LOCATION (City, town, or county) (State) Beallsville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hilton's Funeral Home, Barnesville, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DEC 17 '58		24b. REGISTRAR'S SIGNATURE William B. Nelson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13983

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>8 1/2 hrs 45 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crest View, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>74 Suburban</u>				d. STREET ADDRESS <u>4616 - Bayard Blvd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>J.</u> Last <u>Tennings</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 8, 1882</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>13</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Milton West</u>				14. MOTHER'S MAIDEN NAME <u>Emma Durham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>W. Lena Emeline Fumagalli</u> Address <u>407 - McPherson St. Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause pending for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Insufficiency</u> DUE TO (c) <u>Coronary atherosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>Unknown</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>20 Dec.</u> , 19 <u>58</u> , to <u>21 Dec.</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>21 Dec.</u> , 19 <u>58</u> , and that death occurred at <u>6 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. S. Murphy</u>				M.D. <u>60 W. Montg. Ave. Rockville, Md.</u> DATE SIGNED <u>21 Dec. 58</u>			
PHYSICIAN'S NAME (Type) <u>W. S. Murphy</u>				ADDRESS <u>615 W. Montg. Ave. Rockville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13023

CERTIFICATE OF DEATH

13023

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

1. NAME OF DECEASED <i>James M. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>	
4. PLACE OF BIRTH <i>St. Louis, Mo.</i>		5. DATE OF BIRTH <i>Jan. 15, 1868</i>		6. PLACE OF DEATH <i>Home</i>	
7. OCCUPATION <i>Retired</i>		8. CAUSE OF DEATH <i>Heart failure</i>		9. MEDICAL HISTORY <i>None</i>	
10. DATE OF DEATH <i>Jan. 15, 1933</i>		11. TIME OF DEATH <i>10:30 A.M.</i>		12. PLACE OF INTERMENT <i>St. Louis, Mo.</i>	
13. SIGNATURE OF DECEASED <i>James M. Smith</i>		14. SIGNATURE OF WITNESS <i>John D. Smith</i>		15. SIGNATURE OF PHYSICIAN <i>Dr. J. M. Smith</i>	
16. SIGNATURE OF REGISTRAR <i>John D. Smith</i>		17. SIGNATURE OF CLERK <i>John D. Smith</i>		18. SIGNATURE OF NOTARY <i>John D. Smith</i>	

19. REMARKS
Deceased died at home, after a short illness, of heart failure.

13875

CERTIFICATE OF DEATH

13954

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK, MD	c. LENGTH OF STAY IN 1b 3 y	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EVENTIDE HOME 700 Hudson Ave		d. STREET ADDRESS 7702 Colesville Road	
3. NAME OF DECEASED (Type or print) MARIAN ELIZABETH JOHNSON		4. DATE OF DEATH DEC 10 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-12-69
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Missouri	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? English	
13. FATHER'S NAME Tomlinson		14. MOTHER'S MAIDEN NAME Emma English	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Maurice Johnson		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arterio-sclerotic C.V.R. Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 yrs 4 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1955 to DEC 9 1958 , that I last saw the deceased alive on DEC 9 1958 and that death occurred at 10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.L. Etienne		ADDRESS (Street, city or town, state) 4713-BERWYN RD College Park, MD	
PHYSICIAN'S NAME (Type) W.L. ETIENNE		DATE SIGNED 12/10/58	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 12-10-58	22c. NAME OF CEMETERY OR CREMATORY Lees Crematorium	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - D.C.		ADDRESS	
24a. REC'D BY REGISTRAR DEC 12 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1937

DEPT. OF HEALTH - BALTIMORE

<p>NAME OF DECEASED</p>	
<p>AGE</p>	
<p>SEX</p>	
<p>RACE</p>	
<p>DATE OF BIRTH</p>	
<p>DATE OF DEATH</p>	
<p>PLACE OF DEATH</p>	
<p>CAUSE OF DEATH</p>	
<p>IMMEDIATE CAUSE OF DEATH</p>	
<p>UNDERLYING CAUSE OF DEATH</p>	
<p>PERMANENT CAUSE OF DEATH</p>	
<p>DATE OF EXAMINATION</p>	
<p>SIGNATURE OF PHYSICIAN</p>	
<p>SIGNATURE OF REGISTRAR</p>	
<p>DATE OF REGISTRATION</p>	

DEPT. OF HEALTH - BALTIMORE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13955

13984

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>6 Hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Richard Jones</u>		d. STREET ADDRESS <u>3308 Shepherd Street</u>	
4. DATE OF DEATH Month Day Year <u>12 31 19 58</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 25.1952</u>
9. AGE (In years last birthday) <u>6</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>child</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Canada</u> ✓	
13. FATHER'S NAME <u>William Jones</u>		14. MOTHER'S MAIDEN NAME <u>Adelheid Tampke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>William Jones</u>		Address <u>Same as #2</u> <u>Father</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>812x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of skull</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pedestrian struck by auto</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>3</u> p. m. <u>12-31 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) <u>Chevy Chase Montg Md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Noturol causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		22b. DATE THEREOF <u>1-3-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Royal Cemetery.</u>		22d. LOCATION (City, town, or county) (State) <u>Montreal, Canada.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 5 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>C. S. L. LUNA</u>	

13956

13985 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>9 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>322 Lincoln Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>(Baby Boy) (Newborn) Joppy</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 17, 1958</u>	
9. AGE (In years lost birthday) yrs. <u>9</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min <u>1</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Joppy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Barbara Joppy</u>		Address <u>322 Lincoln Ave Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATELECTASIS</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Hour <u>9</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>12/17</u> , 19 <u>58</u> , to <u>12/18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/18</u> , 19 <u>58</u> , and that death occurred at <u>2:05 AM</u> , from the causes and on the date stated above. <u>Michael L. Buckley</u> ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M.D. PHYSICIAN'S NAME (Type) <u>Michael L. Buckley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/20/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Z. Shamber</u>				ADDRESS <u>Rockville, Md</u>		24a. REC'D BY REGISTRAR <u>DEC 23 58</u>	
				24b. REGISTRAR'S SIGNATURE <u></u>			

2074183XV0

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13957

13876

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 56 Silver Spring,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital				d. STREET ADDRESS 1018 Osage Street,			
3. NAME OF DECEASED (Type or print) First Middle Last Keene				4. DATE OF DEATH Month Day Year December 14, 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 14, 58		9. AGE (In years last birthday) yrs. 20		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME Samuel James Keene				14. MOTHER'S MAIDEN NAME Carolyn Jeanine Nestler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT father		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 758.6 Schondrodyn trophic Foetalia DUE TO Poly dactylaria Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 7 neonatal death DUE TO (c) 18 mins							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-14 , 19 58 , to 12-14-58 , 19 58 , that I last saw the deceased alive on 12-14 , 19 58 , and that death occurred at 2:35 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 934 Ellsworth Dr Silver Spring Md DATE SIGNED 12-14-58 ACTUAL SIGNATURE Kenneth Laughlin M.D. PHYSICIAN'S NAME (Type) Kenneth Laughlin, M. D. 934 Ellsworth Drive, Silver Spring, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 12-15-58		22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium and Hospital		22d. LOCATION (City, town, or county) (State) Takoma Park, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D. Washington Sanitarium and Hospital				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

2075181XV5

DEC 18 58

13216 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

FILE NO.

DATE OF DEATH

AGE

PLACE OF BIRTH

CAUSE OF DEATH

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13986

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 60 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47x-3 d. STREET ADDRESS 4740 Conn. Ave., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Sallie Coleman KING			4. DATE OF DEATH Month Day Year December 3 1958				
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 5, 1900	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) New York			
13. FATHER'S NAME Michael Andrew COLEMAN			14. MOTHER'S MAIDEN NAME Margaret KEYS				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No - - - -		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (H) John W. King, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma, pancreas DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 14 months		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from October 4 , 19 58 , to December 3 , 19 58 , that I last saw the deceased alive on December 3 , 19 58 , and that death occurred at 11:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Douglas R. Koth		M.D. U. S. Naval Hospital, NNMC		DATE SIGNED 12-4-58			
PHYSICIAN'S NAME (Type) D. R. KOTH, LT, MC, USN		Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-8-58	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county)	(State) Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE James J. Dolans ADDRESS Adams Funeral Home, 4748 Wisc. Ave. NW, Wash. DC			24a. REC'D BY REGISTRAR DATE DEC 8 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13987 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>9 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>	
		f. STREET ADDRESS <u>606 Monroe St.</u>	
3. NAME OF DECEASED (Type or print) <u>BABY GIRL KING</u>		4. DATE OF DEATH <u>DECEMBER 9th 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 9th 1958</u>
9. AGE (In years lost birthday) yrs. <u>8</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>8 59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH KIRK KING</u>		14. MOTHER'S MAIDEN NAME <u>ELAINE MARIE SEIDEL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MOTHER</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>Immaturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>premature birth</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/9</u> , 19 <u>58</u> , to <u>12/9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/9</u> , 19 <u>58</u> , and that death occurred at <u>3 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Michael J. Buckley</u>		ADDRESS (Street, city or town, state) <u>4630 Montg. Ave., Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Michael J. Buckley</u>		DATE SIGNED <u>12-9-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-10-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 15 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2174211XVO

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		65		M		W		1898		BALTIMORE, MD.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION	
1963		BALTIMORE, MD.		HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL	
DATE OF INTERMENT		PLACE OF INTERMENT		CEREMONY		BURIAL		CITY		COUNTY	
1963		BALTIMORE, MD.		NATURAL		NATURAL		BALTIMORE		BALTIMORE	
DATE OF REPORT		PLACE OF REPORT		REPORTER		SIGNATURE		TITLE		ADDRESS	
1963		BALTIMORE, MD.		JAMES H. HARRIS		JAMES H. HARRIS		LABORER		BALTIMORE, MD.	

13988 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda

c. LENGTH OF STAY IN 1b 11 hrs.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 Rockville

d. STREET ADDRESS 1 606 Monroe Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last KLING-B

4. DATE OF DEATH Month DECEMBER Day 9 Year 1958

5. SEX FEMALE 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH December 9th 1958

9. AGE (In years last birthday) yrs. 9 IF UNDER 1 YEAR Months 9 Days 5 IF UNDER 24 HRS. Hours 57 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JOSEPH KIRK KLING 14. MOTHER'S MAIDEN NAME ELAINE MARIE SEIDEL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT Mother Address —

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Immaturity
776x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Premature birth
DUE TO (c) —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/9, 1958, to 12/9, 1958, that I last saw the deceased alive on 12/9, 1958, and that death occurred at 5:15 PM, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 4630 Montg. Ave., Bethesda, Md. DATE SIGNED 12-9-58

ACTUAL SIGNATURE Michael U. Buckley PHYSICIAN'S NAME (Type) Michael U. Buckley

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 12-10-58 22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven 22d. LOCATION (City, town, or county) (State) Silver Spring, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, ADDRESS Bethesda, Md. 24a. REC'D BY REGISTRAR DATE DEC 15 '58 24b. REGISTRAR'S SIGNATURE Charles S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2274211XVO

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13
CERTIFICATE OF DEATH

PLACE OF DEATH HOME		MARRIED SINGLE	
1. DATE OF DEATH 1-10-41		2. TIME OF DEATH 10:00 AM	
3. PLACE OF DEATH HOME		4. TIME OF DEATH 10:00 AM	
5. NAME OF DECEASED JOHN J. HENRY		6. SEX MALE	
7. AGE 68		8. RACE WHITE	
9. OCCUPATION RETIRED		10. CAUSE OF DEATH HEART DISEASE	
11. PLACE OF BIRTH BALTIMORE, MD		12. DATE OF BIRTH 1-10-19	
13. NAME OF PHYSICIAN DR. J. H. SMITH		14. NAME OF HOSPITAL ST. JOSEPH'S	
15. NAME OF FUNERAL HOME J. H. SMITH & SONS		16. NAME OF BURIAL PLACE MOUNT RAINIER	
17. NAME OF NEXT OF KIN MRS. J. H. SMITH		18. NAME OF WITNESS DR. J. H. SMITH	
19. NAME OF REGISTRAR J. H. SMITH		20. NAME OF CLERK J. H. SMITH	

This certificate is to be filled out by the physician or other person authorized by the State Department of Health. It is to be filed in the office of the Registrar of the State Department of Health. The certificate is to be signed by the physician or other person authorized by the State Department of Health. The certificate is to be signed by the physician or other person authorized by the State Department of Health.

13989

CERTIFICATE OF DEATH

13961

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) 5026 Alta Vista Road				d. STREET ADDRESS 5026 Alta Vista Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last MARY CATHERINE KNIGHT				4. DATE OF DEATH Month Day Year December 4, 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/7/1911	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months 9 Days 27 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Buffalo, New York	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Wm. J. Murphy				14. MOTHER'S MAIDEN NAME Mary E. Carney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Henry Lloyd-Martin Knight-Item # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 190.9 Intestinal and Liver metastases IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Amelanotic Malignant Melanoma DUE TO (c) 2 1/2 years				INTERVAL BETWEEN ONSET AND DEATH 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Bethesda				20g. (County) Montgomery		20h. (State) Md.	
21. I certify that I attended the deceased from Jan. 21 , 19 52 , to Dec. 4 , 19 58 , that I last saw the deceased alive on December 4 , 19 58 , and that death occurred at 4:47 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert G. Angle				ADDRESS (Street, city or town, state) 5009 Del Ray Ave., Bethesda, Md.			
DATE SIGNED 12/5/58							
PHYSICIAN'S NAME (Type) Robert G Angle 5009 DelRay Avenue, Bethesda, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/6/58		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE DEC 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13990

CERTIFICATE OF DEATH

13962

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OMNEY c. LENGTH OF STAY IN lb 8 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> WOODBINE --Rural 13X-2 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last AUSTIN PETER KNILL				4. DATE OF DEATH Month Day Year DECEMBER 15 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/18/86	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY owner		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME WILLIAM T. KNILL				14. MOTHER'S MAIDEN NAME KATIE WOLFE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS Address SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) MYOCARDIAL INFARCTION DUE TO (c) GENERALIZED ARTERIOSCLEROSIS-SENILE							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF PROSTATE							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3 April</u> , 1954, to <u>15 May</u> , 1958, that I last saw the deceased alive on <u>15 May</u> , 1958, and that death occurred at <u>10: A. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>John B. Ziegler MD</u> M.D. <u>Omney</u> <u>15 May 58</u> PHYSICIAN'S NAME (Type) <u>John B. Ziegler</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-18-1958		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Md.				24a. REC'D BY REGISTRAR DEC 18 '58 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

Y. H. Kuo and S. C. Chen

422

• INTRODUCTION

1 Item 7 Film 6237 1-15-59 et 13991 139963 Reg. Dist. No. 215 1 51 2 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) 15M 10/57

13991 139963 Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 33 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Norfolk c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk d. STREET ADDRESS 534 West 34th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carolyn Middle Sue Last KNOWLES				4. DATE OF DEATH Month December Day 7 Year 19 58			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-18-58	
9. AGE (In years last birthday) yrs. 3		10. AGE (In years last birthday) yrs. 29		11. BIRTHPLACE (State or foreign country) Norfolk, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - - -			
13. FATHER'S NAME William Lee Knowles				14. MOTHER'S MAIDEN NAME Mary Kaythryn ELLIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (F) Wm. L. Knowles, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 DUE TO Arteriosclerotic Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital Heart Disease DUE TO Congenital Heart Disease (c) - - - -							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 4 , 19 58 , to December 7 , 19 58 , that I last saw the deceased alive on December 7 , 19 58 , and that death occurred at 5:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC DATE SIGNED 12-8-58							
ACTUAL SIGNATURE Kenneth W. Sell M.D.				PHYSICIAN'S NAME (Type) Kenneth W. Sell, LT, MC, USN Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 12-9-58		22b. DATE THEREOF 12-9-58		22c. NAME OF CEMETERY OR CREMATORY Little Flock		22d. LOCATION (City, town, or county) (State) Shelburn Indiana	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey ADDRESS Funeral Home, Bethesda, Md.				24a. REC'D BY REGISTRAR DATE DEC 10 '58		24b. REGISTRAR'S SIGNATURE Arthur L. House	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

DECEASED NAME (Last, first, middle) J. B. HAYES, JR.		SEX Male	
DATE OF BIRTH 1914		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Clerk		RESIDENCE 1212 N. E. St. Baltimore, Md.	
DATE OF DEATH 1954		PLACE OF DEATH Baltimore, Md.	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. B. Hayes, Jr.		SIGNATURE OF REGISTRAR J. B. Hayes, Jr.	
SIGNATURE OF WITNESS J. B. Hayes, Jr.		SIGNATURE OF WITNESS J. B. Hayes, Jr.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13877

Item 8, Film G 236 12/5/58 jml

CERTIFICATE OF DEATH

13964

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b 35 years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 TAKOMA PARK				d. STREET ADDRESS 7508 BLAIR ROAD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7508 BLAIR ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WARREN Middle JOHN Last KRAMER				4. DATE OF DEATH Month DEC. Day 2 Year 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/24/85 84	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOP FOREMAN- Public Bldgs. & Park				10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.			
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN CONRAD KRAMER				14. MOTHER'S MAIDEN NAME IDA MARIA DULEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT Mrs. Edith O. Kramer, 7508 Blair Rd. Takoma Park, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary failure edema 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic pulmonary emphysema DUE TO (c) years. INTERVAL BETWEEN ONSET AND DEATH 2 day.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March , 19 56 , to Dec 1 , 19 58 , that I last saw the deceased alive on Dec 1 , 19 58 , and that death occurred at 3:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James R. Coleman MD				ADDRESS (Street, city or town, state) 113 Carroll St NW Washington 12 D.C.			
DATE SIGNED 12/2/58							
PHYSICIAN'S NAME (Type) JAMES R. COLEMAN							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/5/58		22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE DEC 5 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13992 CERTIFICATE OF DEATH

13965

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 20 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1801 GRACE CHURCH ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HENRY Middle BERNARD Last LANDGRAF		4. DATE OF DEATH Month DEC. Day 20 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/19/68
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plate Printer		10b. KIND OF BUSINESS OR INDUSTRY Bureau of Engraving	
11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anton F. Landgraf		14. MOTHER'S MAIDEN NAME Elise Brandau	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Mary S. Landgraf, 1801 Grace Church Rd. Silver Spring, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3-4 days ?			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 10 to 20 Dec. 19 58 , that I last saw the deceased alive on 18 Dec. 19 58 , and that death occurred at 3:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Aud M.D. 9066 Glenville Rd		ADDRESS (Street, city or town, state) DATE SIGNED 12/20/58	
PHYSICIAN'S NAME (Type) WILLIAM D. AUD		Silver Spring	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 12/22/58	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Prince Geo. County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		24a. REC'D BY REGISTRAR DATE DEC 24 '58	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

19393 CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly: JOHN DOE]		SEX [Faint text, possibly: Male]		RACE [Faint text, possibly: White]	
DATE OF BIRTH [Faint text, possibly: Jan 1, 1900]		PLACE OF BIRTH [Faint text, possibly: Baltimore, Md.]		OCCUPATION [Faint text, possibly: Clerk]	
DATE OF DEATH [Faint text, possibly: Dec 1, 1939]		PLACE OF DEATH [Faint text, possibly: Home]		CAUSE OF DEATH [Faint text, possibly: Heart Disease]	
TIME OF DEATH [Faint text, possibly: 10:00 AM]		MANNER OF DEATH [Faint text, possibly: Natural]		SIGNATURE OF PHYSICIAN [Faint text, possibly: J. H. Smith]	
SIGNATURE OF REGISTRAR [Faint text, possibly: W. B. Jones]		SIGNATURE OF WITNESS [Faint text, possibly: A. C. Brown]		SIGNATURE OF DECEASED [Faint text, possibly: John Doe]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13966

13993

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maple Lane Nursing Home</u>				d. STREET ADDRESS <u>5109 Worthington Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BARBARA</u> Middle <u>E</u> Last <u>LANHAM</u>		4. DATE OF DEATH Month <u>DEC</u> Day <u>9</u> Year <u>1958</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/10/1868</u>	9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>29</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Webel</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>B.E. Lanham-son-same as 2d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT. 4</u> , 19 <u>58</u> , to <u>DEC. 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>DEC. 9</u> , 19 <u>58</u> , and that death occurred at <u>11:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry M Lowden</u> M.D.				ADDRESS (Street, city or town, state) <u>5206 Normandy Dr.</u>		DATE SIGNED <u>12/9/58</u>	
PHYSICIAN'S NAME (Type) <u>Henry M Lowden</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/12/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DEC 15 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Cheng Chao, M.D.</u>			

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13994 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13967

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>life</u>		d. STREET ADDRESS <u>11603 Goodloe Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11603 Goodloe Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Dennis Donald Lawer</u>		4. DATE OF DEATH <u>Dec 7 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-12-58</u>
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>25</u> IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>Donald Lawer</u>		14. MOTHER'S MAIDEN NAME <u>Sheila Goulson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Dennis Lawer - Father - Item 2</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>527.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>upper Respiratory Infection</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/9/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DEC 10 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051273XV6

13995

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Market</u> 10X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lawson</u>		4. DATE OF DEATH Month Day Year <u>12 3 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12.3.1958</u>
9. AGE (In years last birthday) yrs. <u>28</u>		10. IF UNDER 1 YEAR Months Days Hours <u>28</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Larry Wayne Lawson</u>		14. MOTHER'S MAIDEN NAME <u>Frances Louise Toms</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Hospital records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Congenital Anomalies</u> 759.3 DUE TO (b) <u>Hydrocephalus</u> (c) <u>Spina bifida</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>3. I.V. septal defect heart</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12.3.</u> 19 <u>58</u> , to <u>12.3.</u> 19 <u>58</u> , that I last saw the deceased alive on <u>12</u> , and that death occurred at <u>2:10 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Gaithersburg, Maryland</u> DATE SIGNED <u>12/3/58</u>			
ACTUAL SIGNATURE <u>Wm. A. Linthicum</u> M.D.		PHYSICIAN'S NAME (Type) <u>William A. Linthicum, M. D.</u> <u>Gaithersburg, Maryland</u> <u>12/3/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 4 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville, Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Laytonsville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W. Barber</u>		24a. REC'D BY REGISTRAR <u>DEC 5 '58</u>	
ADDRESS <u>Laytonsville, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2073233XVV

CERTIFICATE OF DEATH

3. In the State of West Virginia
 I, the undersigned, being a duly qualified
 physician, do hereby certify that

Attest: My hand and seal this 1st day of June, 1908.
 J. M. [Signature]
 Physician

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13969

13996 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 37 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY 77x-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodruff d. STREET ADDRESS Route #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Martha Leonora Leonard			4. DATE OF DEATH Month Day Year December 30, 19 58		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 3, 1915	9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) South Carolina	
13. FATHER'S NAME Lorraine Leonard			14. MOTHER'S MAIDEN NAME Kate Drummond		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Chronic Rheumatic Heart Disease 416x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b). Atrial Septal Defect DUE TO (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21. I certify that I attended the deceased from November 23, 1958 , to December 30, 1958 , that I last saw the deceased alive on December 30, 1958 , and that death occurred at 6:10A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE Leon I. Goldberg		M.D. The Clinical Center		12/30/58	
PHYSICIAN'S NAME (Type) Leon I. Goldberg, M. D.		The National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/30/58		22c. NAME OF CEMETERY OR CREMATORY Antioch	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 2 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13997

CERTIFICATE OF DEATH

13970

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "Daughter's home"				d. STREET ADDRESS 206 Brewster Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MATA Middle - Last LIFTMAN				4. DATE OF DEATH Month December Day 31 , Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ?	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Russia	
13. FATHER'S NAME Eli Barkin				14. MOTHER'S MAIDEN NAME Rose -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Louis Kotz Address 206 Brewster Ave., S. Spg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old age, malnutrition							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 3, 19 58 , to Dec. 31, 19 58 , that I last saw the deceased alive on Dec. 30, 19 58 , and that death occurred at 4:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9210 Colesville Rd., Silver Spring, Md. DATE SIGNED							
ACTUAL SIGNATURE Sydney Leventhal M.D.				PHYSICIAN'S NAME (Type) Sydney Leventhal 9210 Colesville Road, Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 1, 1959		22c. NAME OF CEMETERY OR CREMATORY Ohey Sholom Cem.		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Goldberg Funeral Home 4217 9th Street N.W.				24a. REC'D BY REGISTRAR JAN 2 '59		24b. REGISTRAR'S SIGNATURE John L. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.		10070	
CERTIFICATE OF DEATH			
1. NAME OF DECEASED		2. SEX	
3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION	
7. MARITAL STATUS		8. COLOR	
9. RELIGION		10. EDUCATION	
11. PRESENT ADDRESS		12. DATE OF DEATH	
13. PLACE OF DEATH		14. CAUSE OF DEATH	
15. MEDICAL HISTORY		16. HISTORY OF PRESENT ILLNESS	
17. PHYSICIAN'S SIGNATURE		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF WITNESSES		20. SIGNATURE OF CORONER	
21. SIGNATURE OF JURY		22. SIGNATURE OF JUDGE	
23. SIGNATURE OF CLERK		24. SIGNATURE OF REGISTRAR	
25. SIGNATURE OF NOTARY		26. SIGNATURE OF SHERIFF	
27. SIGNATURE OF DEPUTY SHERIFF		28. SIGNATURE OF CONSTABLE	
29. SIGNATURE OF DEPUTY CONSTABLE		30. SIGNATURE OF JURY	
31. SIGNATURE OF JUDGE		32. SIGNATURE OF CLERK	
33. SIGNATURE OF REGISTRAR		34. SIGNATURE OF SHERIFF	
35. SIGNATURE OF DEPUTY SHERIFF		36. SIGNATURE OF CONSTABLE	
37. SIGNATURE OF DEPUTY CONSTABLE		38. SIGNATURE OF JURY	
39. SIGNATURE OF JUDGE		40. SIGNATURE OF CLERK	
41. SIGNATURE OF REGISTRAR		42. SIGNATURE OF SHERIFF	
43. SIGNATURE OF DEPUTY SHERIFF		44. SIGNATURE OF CONSTABLE	
45. SIGNATURE OF DEPUTY CONSTABLE		46. SIGNATURE OF JURY	
47. SIGNATURE OF JUDGE		48. SIGNATURE OF CLERK	
49. SIGNATURE OF REGISTRAR		50. SIGNATURE OF SHERIFF	
51. SIGNATURE OF DEPUTY SHERIFF		52. SIGNATURE OF CONSTABLE	
53. SIGNATURE OF DEPUTY CONSTABLE		54. SIGNATURE OF JURY	
55. SIGNATURE OF JUDGE		56. SIGNATURE OF CLERK	
57. SIGNATURE OF REGISTRAR		58. SIGNATURE OF SHERIFF	
59. SIGNATURE OF DEPUTY SHERIFF		60. SIGNATURE OF CONSTABLE	
61. SIGNATURE OF DEPUTY CONSTABLE		62. SIGNATURE OF JURY	
63. SIGNATURE OF JUDGE		64. SIGNATURE OF CLERK	
65. SIGNATURE OF REGISTRAR		66. SIGNATURE OF SHERIFF	
67. SIGNATURE OF DEPUTY SHERIFF		68. SIGNATURE OF CONSTABLE	
69. SIGNATURE OF DEPUTY CONSTABLE		70. SIGNATURE OF JURY	
71. SIGNATURE OF JUDGE		72. SIGNATURE OF CLERK	
73. SIGNATURE OF REGISTRAR		74. SIGNATURE OF SHERIFF	
75. SIGNATURE OF DEPUTY SHERIFF		76. SIGNATURE OF CONSTABLE	
77. SIGNATURE OF DEPUTY CONSTABLE		78. SIGNATURE OF JURY	
79. SIGNATURE OF JUDGE		80. SIGNATURE OF CLERK	
81. SIGNATURE OF REGISTRAR		82. SIGNATURE OF SHERIFF	
83. SIGNATURE OF DEPUTY SHERIFF		84. SIGNATURE OF CONSTABLE	
85. SIGNATURE OF DEPUTY CONSTABLE		86. SIGNATURE OF JURY	
87. SIGNATURE OF JUDGE		88. SIGNATURE OF CLERK	
89. SIGNATURE OF REGISTRAR		90. SIGNATURE OF SHERIFF	
91. SIGNATURE OF DEPUTY SHERIFF		92. SIGNATURE OF CONSTABLE	
93. SIGNATURE OF DEPUTY CONSTABLE		94. SIGNATURE OF JURY	
95. SIGNATURE OF JUDGE		96. SIGNATURE OF CLERK	
97. SIGNATURE OF REGISTRAR		98. SIGNATURE OF SHERIFF	
99. SIGNATURE OF DEPUTY SHERIFF		100. SIGNATURE OF CONSTABLE	

13998

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake 158</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>15200 Murray</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dean Jewett Locke</u>				4. DATE OF DEATH Month Day Year <u>12 14 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-14-90</u>		9. AGE (In years lost birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>10 0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Capital Transit</u>		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Horace M. Locke</u>				14. MOTHER'S MAIDEN NAME <u>Eunice Blanchard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>114-00-0000</u>		17. INFORMANT Address <u>Neil Locke 5200 Murray Chesapeake Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>199.2</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Renal Obstruction</u> (c) <u>Abdominal Carcinoma</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 Hours</u> <u>4 Days</u> <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May</u> , 19 <u>58</u> , to <u>Dec 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 14</u> , 19 <u>58</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John C. Humphrey</u>				ADDRESS (Street, city or town, state) <u>1801 Eye St NW Washington</u>			
PHYSICIAN'S NAME (Type) <u>JOHN C. MURRAY MD</u>				DATE SIGNED <u>Dec 14 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/17/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DEC 18 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13999

CERTIFICATE OF DEATH

Reg. Dist. No.

13972

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 9½ yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3002 Blue Ridge Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle AUGUST Last LOFGREN				4. DATE OF DEATH Month DEC. Day 9 Year 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/23/80	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Foreman, Art Metal Work				10b. KIND OF BUSINESS OR INDUSTRY NEW YORK		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME AUGUST LOFGREN				14. MOTHER'S MAIDEN NAME CHRISTINE PETERSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579-01-3487		17. INFORMANT Address Mrs Florence S. Lofgren, 3002 Blue Ridge Ave. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Prostate 177X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/30/56 19____, to 12/9/58 19____, that I last saw the deceased alive on 12/9/58 19____, and that death occurred at 11 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10670 Ga. Ave DATE SIGNED 12/9/58							
ACTUAL SIGNATURE John J. Curry		PHYSICIAN'S NAME (Type) JOHN J. CURRY					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/12/58		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Zick				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE DEC 12 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

14000

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Connecticut b. COUNTY Bridgeport e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Theresa Middle Marie Last Lo Russo				4. DATE OF DEATH Month December Day 3, Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 2, 1918	
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months 45		IF UNDER 24 HRS. Days x		IF UNDER 24 HRS. Hours 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Connecticut	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Michel Ciaurro				14. MOTHER'S MAIDEN NAME Grace Rummo			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 040-16-1666		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypotension in immediate 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) postoperative period - DUE TO (c) Aortic stenosis, ? Congenital						INTERVAL BETWEEN ONSET AND DEATH 24 hrs. ? Congenital	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from November 23, 1958 to December 3, 1958 , that I last saw the deceased alive on December 3, 1958 , and that death occurred at 8:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE N. Perryman Collins				ADDRESS (Street, city or town, state) The Clinical Center			
PHYSICIAN'S NAME (Type) N. Perryman Collins, M. D.				DATE SIGNED 12-3-58			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial-transit 12-4-58				22b. DATE THEREOF 12-4-58			
22c. NAME OF CEMETERY OR CREMATORY St. Michael Cemetery				22d. LOCATION (City, town, or county) (State) Bridgeport, Conn.			
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.			
24a. REC'D BY REGISTRAR DEC 8 '58				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4237-35-0

13878

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chillum</u> 16x22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM</u>		d. STREET ADDRESS <u>6505 Medwick Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>HERMAN</u> Middle <u>G.</u> Last <u>LUNSFORD</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14 - 1901</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POSTAL SUPERVISOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post office</u>	
11. BIRTHPLACE (State or foreign country) <u>Manassas, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James G. Lunsford</u>		14. MOTHER'S MAIDEN NAME <u>Marsteller (aile)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>21428-9232</u>	
17. INFORMANT <u>Emmie V. Lunsford</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerosis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>Indefinite</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 14, 1958</u> to <u>Dec. 15, 1958</u> , that I last saw the deceased alive on <u>Dec. 14, 1958</u> , and that death occurred at <u>12:52 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. B. Little</u>		ADDRESS (Street, city or town, state) <u>6911 5th St. N.W.</u>	
PHYSICIAN'S NAME (Type) <u>A. B. LITTLE MD</u>		DATE SIGNED <u>Washington 12, DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>17 Dec 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Minerva Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Manassas, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert J. Barry</u>		ADDRESS <u>254 Carroll St. N.W.</u>	
24a. REC'D BY REGISTRAR <u>DEC 19 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13879 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Mont.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma PK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma PK.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8519 GLENVIEW AVENUE</u>				e. STREET ADDRESS <u>1 8519 GLENVIEW AVENUE</u>			
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>L.</u> Last <u>MacCallum</u>				4. DATE OF DEATH Month <u>12</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 9, 1903</u>		9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Med. Bacteriologist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hosp</u>		11. BIRTHPLACE (State or foreign country) <u>Mich.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN MCCALLUM</u>				14. MOTHER'S MAIDEN NAME <u>JANE SHIELLS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>374-09-6885</u>		17. INFORMANT Address <u>Miss Margaret J. Carlson, 8519 Glenview Ave. Takoma Park, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast & metastasis to liver, bones</u> 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>9 yrs. 6 mos</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9/13</u> , 19 <u>58</u> , to <u>12/16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/16</u> , 19 <u>58</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Lennard Gold</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>8641 Colesville Rd</u> <u>12/6/58</u> M.D. <u>Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>G. LENNARD GOLD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		22b. DATE THEREOF <u>12/11/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WHITE CHAPEL MEM. CEMETERY, BIRMINGHAM, OAKLAND CO., MICH.</u>		22d. LOCATION (City, town, or county) (State) <u>SILVER SPRING, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Zuka</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Caroline S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14001

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 131 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles Daniel MAC GILLIVRAY				4. DATE OF DEATH Month Day Year December 15 1958			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-21-02		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Diplomatic Service		10b. KIND OF BUSINESS OR INDUSTRY U.S. Dept. of State		11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander A. MAC GILLIVRAY				14. MOTHER'S MAIDEN NAME Florence (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. unknown		17. INFORMANT (W) Dorothy C. MacGillivray, Towers, Arlington, Va.		Address Apt. J939 Arlington	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma DUE TO 200.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 mos						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 9, 1958 , to December 15, 1958 , that I last saw the deceased alive on December 15, 1958 , and that death occurred at 10:36A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE J. T. Horgan				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC DATE SIGNED 12-15-58			
PHYSICIAN'S NAME (Type) J. T. HORGAN, LCDR, MC, USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Shipment 12-16-58		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Pennsylvania	
23. FUNERAL HOME'S SIGNATURE Fitzgerald Funeral Home, 6245 Wilson Blvd, ADDRESS Arlington, Va.				24a. REC'D BY REGISTRAR DEC 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10001

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

See this form

1. Name of deceased (Print name and last name) J. Edgar Hoover	
2. Date of death April 5, 1965	
3. Place of death Washington, D.C.	
4. Cause of death (List all causes, beginning with the immediate cause) Myocardial infarction	
5. Date and place of birth January 20, 1894, Washington, D.C.	
6. Sex Male	
7. Race White	
8. Marital status Married	
9. Occupation Director, Federal Bureau of Investigation	
10. Signature of physician J. Edgar Hoover	
11. Signature of registrar J. Edgar Hoover	
12. Date of registration April 5, 1965	
13. Place of registration Baltimore, Md.	
14. Signature of registrar J. Edgar Hoover	
15. Date of registration April 5, 1965	
16. Place of registration Baltimore, Md.	
17. Signature of registrar J. Edgar Hoover	
18. Date of registration April 5, 1965	
19. Place of registration Baltimore, Md.	
20. Signature of registrar J. Edgar Hoover	
21. Date of registration April 5, 1965	
22. Place of registration Baltimore, Md.	
23. Signature of registrar J. Edgar Hoover	
24. Date of registration April 5, 1965	
25. Place of registration Baltimore, Md.	
26. Signature of registrar J. Edgar Hoover	
27. Date of registration April 5, 1965	
28. Place of registration Baltimore, Md.	
29. Signature of registrar J. Edgar Hoover	
30. Date of registration April 5, 1965	
31. Place of registration Baltimore, Md.	
32. Signature of registrar J. Edgar Hoover	
33. Date of registration April 5, 1965	
34. Place of registration Baltimore, Md.	
35. Signature of registrar J. Edgar Hoover	
36. Date of registration April 5, 1965	
37. Place of registration Baltimore, Md.	
38. Signature of registrar J. Edgar Hoover	
39. Date of registration April 5, 1965	
40. Place of registration Baltimore, Md.	
41. Signature of registrar J. Edgar Hoover	
42. Date of registration April 5, 1965	
43. Place of registration Baltimore, Md.	
44. Signature of registrar J. Edgar Hoover	
45. Date of registration April 5, 1965	
46. Place of registration Baltimore, Md.	
47. Signature of registrar J. Edgar Hoover	
48. Date of registration April 5, 1965	
49. Place of registration Baltimore, Md.	
50. Signature of registrar J. Edgar Hoover	
51. Date of registration April 5, 1965	
52. Place of registration Baltimore, Md.	
53. Signature of registrar J. Edgar Hoover	
54. Date of registration April 5, 1965	
55. Place of registration Baltimore, Md.	
56. Signature of registrar J. Edgar Hoover	
57. Date of registration April 5, 1965	
58. Place of registration Baltimore, Md.	
59. Signature of registrar J. Edgar Hoover	
60. Date of registration April 5, 1965	
61. Place of registration Baltimore, Md.	
62. Signature of registrar J. Edgar Hoover	
63. Date of registration April 5, 1965	
64. Place of registration Baltimore, Md.	
65. Signature of registrar J. Edgar Hoover	
66. Date of registration April 5, 1965	
67. Place of registration Baltimore, Md.	
68. Signature of registrar J. Edgar Hoover	
69. Date of registration April 5, 1965	
70. Place of registration Baltimore, Md.	
71. Signature of registrar J. Edgar Hoover	
72. Date of registration April 5, 1965	
73. Place of registration Baltimore, Md.	
74. Signature of registrar J. Edgar Hoover	
75. Date of registration April 5, 1965	
76. Place of registration Baltimore, Md.	
77. Signature of registrar J. Edgar Hoover	
78. Date of registration April 5, 1965	
79. Place of registration Baltimore, Md.	
80. Signature of registrar J. Edgar Hoover	
81. Date of registration April 5, 1965	
82. Place of registration Baltimore, Md.	
83. Signature of registrar J. Edgar Hoover	
84. Date of registration April 5, 1965	
85. Place of registration Baltimore, Md.	
86. Signature of registrar J. Edgar Hoover	
87. Date of registration April 5, 1965	
88. Place of registration Baltimore, Md.	
89. Signature of registrar J. Edgar Hoover	
90. Date of registration April 5, 1965	
91. Place of registration Baltimore, Md.	
92. Signature of registrar J. Edgar Hoover	
93. Date of registration April 5, 1965	
94. Place of registration Baltimore, Md.	
95. Signature of registrar J. Edgar Hoover	
96. Date of registration April 5, 1965	
97. Place of registration Baltimore, Md.	
98. Signature of registrar J. Edgar Hoover	
99. Date of registration April 5, 1965	
100. Place of registration Baltimore, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13977

13880

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville, Md. 1615.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San. & Hospital		d. STREET ADDRESS 8200 14th Avenue	
3. NAME OF DECEASED (Type or print) First DEBRA Middle ROSE Last MARCUS		4. DATE OF DEATH Month December Day 26 , Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1891
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) London, England		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Silverberg		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-07-2644	
17. INFORMANT Leah Holober		Address 821 Ray Road, Hyattsville, Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute cardiac standstill 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Thrombosis DUE TO (c) Coronary arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 Month several yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 2, 1958 , to Dec. 26, 1958 , that I last saw the deceased alive on Dec. 15, 1958 , and that death occurred at 8:13 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Benjamin Manchester</i>		ADDRESS (Street, city or town, state) 3200 - 16th Street N.W. Washington, D.C.	
PHYSICIAN'S NAME (Type) Dr. Benjamin Manchester		DATE SIGNED Dec. 26, 1958	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/28/58	22c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Cemetery	22d. LOCATION (City, town, or county) (State) Hyattsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Franklin S. Green</i>		24a. REC'D BY REGISTRAR DEC 29 '58	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Green</i>			

14002

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1202-GODWIN DRIVE				d. STREET ADDRESS 1202-GODWIN DRIVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First BENJAMIN Middle - Last MARGOLIS				4. DATE OF DEATH Month DEC. Day 7 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 11, 1919	
9. AGE (In years lost birthday) yrs. 39		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME DAVID SAUL MARGOLIS				14. MOTHER'S MAIDEN NAME ROSE GREENBERG			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) W-W-11		17. INFORMANT Address RUTH MARGOLIS-1202-GODWIN DR. S.S. MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aspiration of vomitus (c) Coronary occlusion - acute							INTERVAL BETWEEN ONSET AND DEATH 3.5 minutes undetermined - 1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March , 19 56 to Dec. 7 , 19 58 , that I last saw the deceased alive on December 7, 1958 , and that death occurred at 2:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 931 PERSHING DRIVE 12-7-58 ACTUAL SIGNATURE Jason Geiger M.D. Silver Spring, MD. PHYSICIAN'S NAME (Type) JASON GEIGER							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 8, 1958		22c. NAME OF CEMETERY OR CREMATORY ADAS ISRAEL CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY				ADDRESS 5014 3501-14th ST. N.W.		24a. REC'D BY REGISTRAR DEC 8 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. K...							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14003

CERTIFICATE OF DEATH

13979

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First REGINA Middle ANNE Last MARON				4. DATE OF DEATH Month December Day 3 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 11, 1930		9. AGE (In years lost birthday) 28 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 22 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S
13. FATHER'S NAME Chester A. Hammett				14. MOTHER'S MAIDEN NAME Rose Redman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Joseph O Maron-husband-same as 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 501x Bilateral confluent bronchopneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Tracheobronchitis DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 24 hours 24 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 081x Residuals of bulbar polio							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month Day Year 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Nov. 24, 1958 to DEC. 3, 1958 , that I last saw the deceased alive on DECEMBER 3, 1958 , and that death occurred at 4:30 A.M. , from the causes and on the date stated above.							DATE SIGNED DEC 3, 1958
ACTUAL SIGNATURE Joseph D. Connor		ADDRESS (Street, city or town, state) 9420 OLD GEORGETOWN RD. Bethesda Md					
PHYSICIAN'S NAME (Type) Joseph D. Connor		ADDRESS 9600 Old Georgetown Rd. Bethesda Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/6/58		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Prince George County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey, Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE DEC 4 '58		24b. REGISTRAR'S SIGNATURE Charles S. Hines	

Coroner notified-7:00 AM-12/3/58

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14004

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 5 days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 4801 4th Street, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Fred Middle Joseph Last MARONI				4. DATE OF DEATH Month December Day 28 Year 19 58									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-26-97		9. AGE (In years last birthday) yrs. 61		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab driver				10b. KIND OF BUSINESS OR INDUSTRY - - -				11. BIRTHPLACE (State or foreign country) Vermont				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin MARONI				14. MOTHER'S MAIDEN NAME Teresa BATTAINI									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI				16. SOCIAL SECURITY NO. 018-10-2179				17. INFORMANT (S) Mrs. Elsie A. Inscoe, same as #2 above					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 492x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchial obstruction & Mucus plugs DUE TO (c) Pneumonia Right lower lobe. INTERVAL BETWEEN ONSET AND DEATH Immediate ? Hours. 7 days													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of larynx - resected 5 years ago													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Tracheostomy									
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Tracheostomy		(County) (State)			
21. I certify that I attended the deceased from December 23, 19 58 , to December 28, 19 58 , that I last saw the deceased alive on December 27, 19 58 , and that death occurred at 6:30P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda 14, Maryland DATE SIGNED 12-29-58													
ACTUAL SIGNATURE August Miale Jr.				M.D. U. S. Naval Hospital				DATE SIGNED 12-29-58					
PHYSICIAN'S NAME (Type) August MIALE, JR.				ADDRESS Bethesda 14, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-31-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia					
23. FUNERAL DIRECTOR'S SIGNATURE W. Chambers				ADDRESS 1400 Chapin St., NW, Washington, DC				24a. REC'D BY REGISTRAR DEC 30 58		24b. REGISTRAR'S SIGNATURE W. Chambers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14005

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 15 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 3406 Ferndale Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle Herbert Last Martin				4. DATE OF DEATH Month December Day 20 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1895		9. AGE (In years lost birthday) 63 yrs.	10. UNDER 1 YEAR Months 15 Days hr	11. UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Patrolman, Washington Terminal				10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Duvall				14. MOTHER'S MAIDEN NAME Ella Dwyer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 718-14-922		17. INFORMANT Ruby F. Martin		Address 3406 Ferndale St. Kensington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Right Heart failure DUE TO (c) Cor pulmonale						INTERVAL BETWEEN ONSET AND DEATH 15 hr 15 hr Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema, severe						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1953 , 19____, to Dec 20 , 19 58 , that I last saw the deceased alive on Dec 19 , 19 58 , and that death occurred at 1:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10,511 Summit Ave., Kensington, Md. DATE SIGNED 12/20/58							
ACTUAL SIGNATURE George Sharpe MD				M.D. 10,511 Summit Ave., Kensington, Md.			
PHYSICIAN'S NAME (Type) GEORGE SHARPE							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/23/58		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE DEC 24 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14006 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 72 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Worth c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worth d. STREET ADDRESS (No street address) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William (None) Martin		4. DATE OF DEATH Month Day Year December 2, 1958	
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 14, 1939
9. AGE (In years last birthday) yrs. 19		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Instrumentalist		10b. KIND OF BUSINESS OR INDUSTRY Unascertainable	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Nathaniel Martin		14. MOTHER'S MAIDEN NAME Daisy Heskins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aortic Insufficiency DUE TO 4/6X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic Heart Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 15 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 21, 1958 , to December 2, 1958 , that I last saw the deceased alive on December 2, 1958 , and that death occurred at 8:24 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edgar Haber (for the doctor)		ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 12-2-58	
PHYSICIAN'S NAME (Type) Edgar Haber, M. D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 12/3/58	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) Keystone, West Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. McGuire		ADDRESS 18209th St., N.W.	
24a. REC'D BY REGISTRAR DATE DEC 5 '58		24b. REGISTRAR'S SIGNATURE Carl E. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried with the registrator prior to burial, cremation, or removal, and in any event within 72 hours after death.

3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13983

14007

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDeau Gardens Nursing Home		d. STREET ADDRESS 1024 University Blvd. East	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Isam Middle Mason Last Mason		4. DATE OF DEATH Month December Day 10 Year 1958	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 14, 1882
9. AGE (In years last birthday) 76		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Automobile	
11. BIRTHPLACE (State or foreign country) Franklin County, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Mason		14. MOTHER'S MAIDEN NAME Charity Cooper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578 01 4559	
17. INFORMANT Lawrence B. Mason, (same as #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure 420.1 DUE TO Arteriosclerotic Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Possible Coronary Occlusion DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Pyelonephritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 13, 1958 to Dec 10, 1958 , that I last saw the deceased alive on Dec 9, 1958 and that death occurred at 10:15 a.m. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 10609 Concord Street	
ACTUAL SIGNATURE Robert T. Thibadeau, M.D.		DATE SIGNED Dec 10-58	
PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.		Kensington, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 13, 1958	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Rossini, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE TAKOMA FUNERAL HOME		24a. REC'D BY REGISTRAR 254 Carroll Street NW	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE DEC 15 '58	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES H. HARRIS		Male		45		1890		Baltimore, Md.		Carpenter		Married		White	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. DISEASE OR INJURY		14. PERIOD OF ILLNESS		15. PREVIOUS ILLNESS		16. SIGNATURE OF PHYSICIAN	
1940		10:00 AM		Home		Heart Disease		Coronary Artery Disease		2 weeks		None		J. H. Harris	
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF PHYSICIAN		21. SIGNATURE OF CHURCH CLERGYMAN		22. SIGNATURE OF FUNERAL HOME		23. SIGNATURE OF BURIAL PLACE		24. SIGNATURE OF INTERVIEWER	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND, FOR THE PURPOSE OF RECORDING AND STATISTICAL PURPOSES.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14008

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13984

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <u>R-7.D. #3</u>	
3. NAME OF DECEASED (Type or print) <u>Candrey Wilmer McCrossin</u>		4. DATE OF DEATH <u>Dec 6 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-30-88</u>
9. AGE (in years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>6</u>	
11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Wesley McCrossin</u>		14. MOTHER'S MAIDEN NAME <u>Annis Y. Kelly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Flora McCrossin (wife)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12-6-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/10/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Church</u>		22d. LOCATION (City, town, or county) (State) <u>Darnestown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>DEC 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

14009

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 15 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 4312 Mahan Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joyce Middle Helen Last McIntyre		4. DATE OF DEATH Month December Day 9 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1915
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. JOHN MASON		14. MOTHER'S MAIDEN NAME Gertrude MALLON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 579-38-0652	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of breast DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH undetermined 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 8, 19 58 to Dec. 9, 19 58 , that I last saw the deceased alive on Dec. 9, 19 58 , and that death occurred at 3:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Tuohy		DATE SIGNED 12/9/58	
PHYSICIAN'S NAME (Type) JOHN H. TUOHY		ADDRESS (Street, city or town, state) 7720 WISCONSIN AVE BETHESDA 14, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/11/58	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska		24a. REC'D BY REGISTRAR DEC 12 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

700 Dec 4, 1958 DRB Bockhart Notified -

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13986

Reg. Dist. No.

14010

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD #3 Gaithersburg		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maurice Middle Francis Last McLoughlin		4. DATE OF DEATH Month Dec. Day 16 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Printing	
11. BIRTHPLACE (State or foreign country) Sturgis, Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William McLoughlin		14. MOTHER'S MAIDEN NAME Carolyn McLoughlin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Kenneth D. Miller		Address RFD #3 Gaithersburg, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO AND (c) essential hypertension INTERVAL BETWEEN ONSET AND DEATH 15 minutes years 2 years -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 30 , 19 57 , to Dec. 16 , 19 58 , that I last saw the deceased alive on Aug. 15 , 19 58 , and that death occurred at 9:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 615 W. Montgomery Ave., Rockville, Md. DATE SIGNED 12/17/58			
ACTUAL SIGNATURE Stephen C. Cromwell M.D.		PHYSICIAN'S NAME (Type) Stephen C. Cromwell, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12.19.58	22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	22d. LOCATION (City, town, or county) (State) Georgia Ave. Mont. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Samuel C. Latham		24a. REC'D BY REGISTRAR DATE DEC 22 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
14011 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13987

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>2 mo.</u>		d. STREET ADDRESS <u>6705 Brigadoon Dr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6705 Brigadoon Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna Milicke</u>		4. DATE OF DEATH <u>12-25-1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-18-92</u>
9. AGE (In years last birthday) <u>66 yrs.</u>		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown Jonelunas</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>291-01-5130</u>	
17. INFORMANT <u>Adde Keller (daughter)</u>		Address <u>Stun 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12-25-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/25/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DEC 30 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14012

CERTIFICATE OF DEATH

Reg. Dist. No. 13988

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>9200 Wisconsin Ave</u>				d. STREET ADDRESS <u>15111 Manning Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY HART MILLER</u>				4. DATE OF DEATH Month Day Year <u>12 4 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1873</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Arlington County</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert Miller</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Lucille Miller Jones</u> Address <u>5111 Manning Dr. Bethesda, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Wrenema</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>congestive heart failure</u> DUE TO (c) <u>Hypertensive cardiovascular disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>21 days</u> <u>10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, generalized</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1954</u> to <u>Dec. 4</u> , 1958, that I last saw the deceased alive on <u>Dec. 4</u> , 1958, and that death occurred at <u>5:45</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert H. Coale</u> M.D.				ADDRESS (Street, city or town, state) <u>4630 Montgomery Ave. Bethesda, Md.</u> DATE SIGNED <u>12/4/58</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/6/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemt.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph A. Birchbom</u> ADDRESS <u>Washington, D. C.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneale</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13881

CERTIFICATE OF DEATH

13989

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>7600 Morningside Dr. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>Alice</u> Last <u>Miller</u>				4. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-10-92</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>14</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Walker</u>				14. MOTHER'S MAIDEN NAME <u>Belle Horsfall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Hospital Records</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY INFARCTS</u> <u>356.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>AMYOTROPHIC LATERAL SCLEROSIS</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u> <u>2 year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>APR. 26, 1958</u> , to <u>Dec. 15, 1958</u> , that I last saw the deceased alive on <u>Dec. 14, 1958</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6911 5th N.W., WASH. DC</u> DATE SIGNED <u></u> ACTUAL SIGNATURE <u>Or Little</u> M.D. <u></u> PHYSICIAN'S NAME (Type) <u>A. B. LITTLE, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>12/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Alexandria Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Alexandria, Kentucky</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. - 2901 14th St. N.W. Washington, DC</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 17 58</u>		24b. REGISTRAR'S SIGNATURE <u></u>	

CERTIFICATE OF DEATH

1934

File No.

PLACE OF DEATH (City, town, village, or place) _____		COUNTY _____	
SEX OF DECEASED (Male or Female) _____		AGE OF DECEASED (In years, months, and days) _____	
OCCUPATION OF DECEASED _____		CAUSE OF DEATH (Immediate cause) _____	
PLACE OF BIRTH (City, town, village, or place) _____		DATE OF BIRTH (Month, day, and year) _____	
MARITAL STATUS (Single, married, widowed, divorced) _____		DATE OF DEATH (Month, day, and year) _____	
TIME OF DEATH (Hour and minute) _____		PLACE OF INTERMENT (City, town, village, or place) _____	
NAME OF PHYSICIAN _____		NAME OF FUNERAL HOME _____	
NAME OF WITNESS _____		NAME OF REGISTRAR _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF REGISTRAR _____	

MADE BY THE
 DEPARTMENT OF HEALTH
 BALTIMORE, MARYLAND
 1934

14013

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRINGS		c. LENGTH OF STAY IN 1b 3 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1501 DILSTON ST				d. STREET ADDRESS 1154 DILSTON ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ISAAC Middle — Last MILLMAN				4. DATE OF DEATH Month 12 Day 22 Year 1958			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb - 1892	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Grocer		10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob				14. MOTHER'S MAIDEN NAME Bessie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-24-2793		17. INFORMANT Hyman Millman Address 1501 Dilston St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Instant - 10 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X DIABETES MELLITUS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-15-58 , 1958, to 12-22- , 1958, that I last saw the deceased alive on 12-21- , 1958, and that death occurred at 4:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 915 197th ST NW Wash DC 12-22-58							
ACTUAL SIGNATURE Lewis H. Biben				M.D. 915 197th ST NW Wash DC 12-22-58			
PHYSICIAN'S NAME (Type) LEWIS H. BIBEN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/23-1958		22c. NAME OF CEMETERY OR CREMATORY Southwest Hebrew Burial		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home Wash DC				24a. REC'D BY REGISTRAR DATE DEC 23 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15000

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES J. BROWN		AGE 45		SEX Male		RACE White		DATE OF DEATH 1912	
PLACE OF BIRTH New York		CITY OF BIRTH New York		CITY OF DEATH Boston		STATE OF DEATH Massachusetts		COUNTRY OF BIRTH United States	
OCCUPATION Carpenter		EDUCATION High School		MARRIAGE Married		RELIGION Roman Catholic		MARITAL STATUS Widow	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PERIOD OF ILLNESS Several weeks		PLACE OF DEATH Home		ATTENDING PHYSICIAN Dr. J. H. Smith	
DATE OF BURIAL 1912		PLACE OF BURIAL St. Mary's Church		CITY OF BURIAL Boston		STATE OF BURIAL Massachusetts		COUNTRY OF BURIAL United States	
SIGNATURE OF DECEASED James J. Brown		SIGNATURE OF NEXT OF KIN John Brown		SIGNATURE OF PHYSICIAN Dr. J. H. Smith		SIGNATURE OF CLERK J. H. Smith		SIGNATURE OF REGISTRAR J. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14014

CERTIFICATE OF DEATH

13991

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE EXX Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) Kensington Gardens Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mrs. Maude E. Mills		4. DATE OF DEATH Month Day Year 12 3 19 58	
5. SEX F	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-4-1881
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thompson		14. MOTHER'S MAIDEN NAME Unobtainable	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. ER. Bishop, 411 Meadow Lane, Falls Ch. Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Congestive Heart Failure DUE TO (b) Arteriosclerosis DUE TO (c) Serility		INTERVAL BETWEEN ONSET AND DEATH 1 month yes yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 12, 1956 , to 12/3/58 , 19____, that I last saw the deceased alive on 12/2/58 , 19____, and that death occurred at 10:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Kensington, MD DATE SIGNED 12/3/58 ACTUAL SIGNATURE SAM ALLEN M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12/5/58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR DEC 8 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank		24c. ADDRESS 2901 14th St. N.W. Washington 9, D.C.	

CERTIFICATE OF DEATH

1901

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Witness	
John Doe		45		Male		White		White		Roman Catholic		Single		Teacher		Heart Disease		Home		Jan 15		10:00 AM		J. A. Smith		M. B. Jones		W. C. Brown	
Place of Birth		Date of Birth		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition	
New York City		Jan 1, 1856		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901	
Place of Death		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition	
Home		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901	
Cause of Death		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition	
Heart Disease		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901	
Place of Death		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition	
Home		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901	
Cause of Death		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition	
Heart Disease		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901		Jan 15, 1901	

NOTARY PUBLIC

This is to certify that the foregoing is a true and correct copy of the original as the same appears in the files of the Department of Health of the State of Maryland, and that the same has been compared with the original and found to be correct.

Notary Public

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13992

14015

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWARD Middle KEEFER Last MOBLEY		4. DATE OF DEATH Month December Day 30 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 4, 1880
9. AGE (In years birthday) 78 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Gaurd		10b. KIND OF BUSINESS OR INDUSTRY Tel. Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jefferson Mobley		14. MOTHER'S MAIDEN NAME Mattie Funk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-07-8297	
17. INFORMANT Mr. George W. Dronenburg-Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary occlusion DUE TO (c) Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 day 2 days 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 29, 1957 to Dec 30, 1958 , that I last saw the deceased alive on Dec 29, 1958 , and that death occurred at 8:30 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 12/30/58			
ACTUAL SIGNATURE Vernon E. Martens M.D.			
PHYSICIAN'S NAME (Type) Dr. Vernon Martens		Germantown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-3-59	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Mr. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE JAN 5 '59	24b. REGISTRAR'S SIGNATURE Arthur E. Funnell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

LOCALITY		COUNTY		STATE	
BALTIMORE		BALTIMORE		MARYLAND	
DECEASED		DATE OF DEATH		AGE	
JOHN J. KENTON		JAN 21 1907		35	
RESIDENCE		OCCUPATION		CAUSE OF DEATH	
BALTIMORE		LABORER		HEART DISEASE	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION	
JAN 21 1872		BALTIMORE		HIGH SCHOOL	
MARRIAGE		SPOUSE		MANNER OF DEATH	
MARRIED		MRS. J. KENTON		NATURAL	
RELIGION		RACE		SEX	
METHODIST		WHITE		MALE	
PREVIOUS ILLNESS		TREATMENT		POST-MORTEM	
NONE		NONE		NONE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN	
JOHN J. KENTON		J. KENTON		J. KENTON	
DATE		PLACE		STATE	
JAN 21 1907		BALTIMORE		MARYLAND	

14016

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Evert</u> Last <u>Molter</u>				4. DATE OF DEATH Month <u>December</u> Day <u>19</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 27, 1898</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Marine Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant Marine</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Richard Molter</u>			
14. MOTHER'S MAIDEN NAME <u>Adela Stockstill</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>055-03-5120</u>		17. INFORMANT <u>The Medical Record</u> <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>METASTATIC CARCINOMA of HYPOPHARYNX</u> DUE TO (c) <u>9 MONS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 16, 1958</u> , to <u>December 19, 1958</u> , that I last saw the deceased alive on <u>December 19, 1958</u> , and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>Bethesda 14, Maryland</u> DATE SIGNED <u>12-20-58</u>							
ACTUAL SIGNATURE <u>I. Bernard Weinstein</u>		PHYSICIAN'S NAME (Type) <u>I. BERNARD WEINSTEIN</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Burial-transit 12-21-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glendale Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bloomfield, New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 24 58</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13994

14017

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 3, Film G-237 12/19/58.c

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Darnestown - Rural

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Darnestown - Rural

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

R. F. D. #3, Gaithersburg,

/d. STREET ADDRESS

R. F. D. #3, Gaithersburg,

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

MARSHALL

P.

MONEYMAKER

4. DATE
OF
DEATH

Month

Day

Year

December 11 1958

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

May 4, 1901

9. AGE (In years
last birthday)

57 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

7 7 7

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Plumber

10b. KIND OF BUSINESS OR INDUSTRY

Plumbing

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

US

13. FATHER'S NAME

James Moneymaker

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

217-07-3415

17. INFORMANT

Address

Isabel Bogley-daughter-same as 2d

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH
sudden420.1
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.

19

20d. INJURY OCCURRED
While of work ☐ Not while of work ☐20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐ACTUAL
SIGNATURE

Frank J. Broschart

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ASSISTANT MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)

Frank J. Broschart

DEPUTY MEDICAL EXAMINER ☒

12-11-58

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

12/13/58

22c. NAME OF CEMETERY OR CREMATORY

Rockville Cemetery

22d. LOCATION (City, town, or county)

Rockville, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey Bethesda, Maryland

24a. REC'D BY REGISTRAR

DEC 15 '58

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13882

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp.</u>				e. STREET ADDRESS <u>10810 Blossom Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Hatch</u> Last <u>Morehouse</u>				4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>fe</u>	6. COLOR OR RACE <u>wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-6-86</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Vermont</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Henry H. Hibbins</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Paddock</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Pl's hosp. Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease.</u> (c) <u>5 years</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>renal insufficiency (anemia)</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov.</u> , 1956, to <u>Nov Dec</u> , 1958, that I last saw the deceased alive on <u>Dec 1st</u> , 1958, and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Veronica Troost</u> M.D. <u>10401 N.W. Oak Silver Spring, Md.</u>				PHYSICIAN'S NAME (Type) <u>VERONIKA TROOST MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>COLUMBIA GARDENS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thayer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

...the ... of ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13883

CERTIFICATE OF DEATH

13996

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN TB <u>3 hr 1/2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>				e. STREET ADDRESS <u>10014 Sutherland Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Aloysius</u> Last <u>Murphy</u>				4. DATE OF DEATH Month <u>DEC.</u> Day <u>4</u> Year <u>19 58</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>wh.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/22/96</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>owner Chacco Greetings</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>& Printing Co.</u>			
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>American</u>			
13. FATHER'S NAME <u>John Murphy</u>				14. MOTHER'S MAIDEN NAME <u>MARY Cosgrove</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-10-3985</u>		17. INFORMANT <u>PH's Hosp. Record</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Right Lung</u> DUE TO <u>Terminal cachexia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>163X</u> DUE TO (c) <u>1wk</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 25</u> , 19 <u>58</u> , to <u>Dec 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-4</u> , 19 <u>58</u> , and that death occurred at <u>3:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Kenneth F. Laughlin</u> M.D.				DATE SIGNED <u>12-4-58</u>			
PHYSICIAN'S NAME (Type) <u>KENNETH F. LAUGHLIN</u>				ADDRESS <u>934 Elbowood Dr. Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Jaska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 8 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>							

13483
 CERTIFICATE OF DEATH
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED MARY ANN BROWN		PLACE OF BIRTH BALTIMORE, MARYLAND	
DATE OF BIRTH JANUARY 15, 1890		PLACE OF DEATH BALTIMORE, MARYLAND	
SEX FEMALE		RACE WHITE	
OCCUPATION SEWING MACHINE REPAIRER		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		TIME OF DEATH 10:30 A.M.	
PLACE OF DEATH 1234 E. BALTIMORE ST. BALTIMORE, MARYLAND		NAME OF PHYSICIAN DR. J. H. SMITH	
NAME OF FUNERAL HOME BROWN & SONS		NAME OF MINISTER REV. J. W. DAVIS	
NAME OF BURIAL PLACE GREENWICH CEMETERY		NAME OF CLERGYMAN REV. J. W. DAVIS	
NAME OF NEXT OF KIN MRS. J. H. BROWN		NAME OF WITNESS DR. J. H. SMITH	
NAME OF REGISTRAR J. H. BROWN		NAME OF CLERK J. H. BROWN	

13483
 CERTIFICATE OF DEATH
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

14018

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 1 1/2 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sharon Nursing Home		d. STREET ADDRESS 4709--66th Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WINIFRED Middle AGNES Last MYERS		4. DATE OF DEATH Month December Day 31st Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16th, 1892
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Waltham, Mass.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Simon Pollard		14. MOTHER'S MAIDEN NAME Catherine L. Gore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT John G. Myers, 4709--66th Place, Hyattsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized & cerebral arteriosclerosis DUE TO associated with senility (c) malnutrition		INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs several yrs several mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 19 , 19 58 , to Dec 31 , 19 58 , that I last saw the deceased alive on Dec 29 , 19 58 , and that death occurred at 11:50 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John R. Spencer M.D. Burtonsville, Md.		DATE SIGNED 1-2-59	
PHYSICIAN'S NAME (Type) John R. Spencer		Burtonsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/3/1959	22c. NAME OF CEMETERY OR CREMATORY Pawtuxet Cemetery	22d. LOCATION (City, town, or county) (State) Lakewood, Rhode Island
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE JAN 5 '59	
		24b. REGISTRAR'S SIGNATURE Caroline S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13998

14019

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P.H.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>1 hr</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSP</u>		d. STREET ADDRESS <u>3424 Tulane Drive</u>	
3. NAME OF DECEASED (Type or print) <u>BBBY GIRL</u> First <u>NORMANDY</u> Middle <u>NORMANDY</u> Last <u>NORMANDY</u>		4. DATE OF DEATH <u>DECEMBER 18</u> 19 <u>58</u> Month <u>18</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 18 1958</u>
9. AGE (In years last birthday) <u>1 hr</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>20</u> Hours <u>1</u> Min. <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Willard Davis Normandy</u>		14. MOTHER'S MAIDEN NAME <u>Marion Kisser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>Father Willard Davis Normandy</u> Address <u>—</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 FTELECTASIS</u> DUE TO <u>PRIEMATURE - 1 POUND BABY.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Hour <u>—</u> o. m. <u>—</u> p. m. <u>—</u> Month <u>—</u> Day <u>19</u> Year <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>—</u>
21. I certify that I attended the deceased from <u>12-18</u> , 19 <u>58</u> , to <u>12-18-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-18-58</u> , 19 <u>58</u> , and that death occurred at <u>9:25 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>544 W. MONTGOMERY, ROCKVILLE</u> DATE SIGNED <u>12-18</u> ACTUAL SIGNATURE <u>William Frank</u> M.D. <u>—</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM FRANK, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Disposal</u>	22b. DATE THEREOF <u>12/30/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sec Washington Medical School</u>	22d. LOCATION (City, town, or county) (State) <u>1335 H St. NW. Wash. D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>DEC 24 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SS



14020

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Lancaster			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kilmarnock 83X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5515 Cedar Parkway				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle A. Last Nugent				4. DATE OF DEATH Month Dec. Day 28th. Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/8/1900		9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. U. S. Govt.		10b. KIND OF BUSINESS OR INDUSTRY Navy Dept.		11. BIRTHPLACE (State or foreign country) Alexandria, Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Owen J. Nugent				14. MOTHER'S MAIDEN NAME Bertha Hall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT (Widow) Elizabeth Tiffey Nugent -Kilmarnock, Va. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)						INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1956, to 12/28 1958, that I last saw the deceased alive on 12/28 1958, and that death occurred at 5 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5707 Wisconsin Ave DATE SIGNED 12/28/58 ACTUAL SIGNATURE Frank Y. Jagger Jr. M.D. Chevy Chase, Md. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/31/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph F. Buck's Sons ADDRESS 3034 M ST NW WASH, DC				24a. REC'D BY REGISTRAR DATE JAN 2 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH—04-13-1996, 15

1954

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14000

14021

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY New York c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York			
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Joseph		First Joseph		Middle Felix		Last O'Boyle	
4. DATE OF DEATH December 8, 1958		Month December		Day 8		Year 1958	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 28, 1921	
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bell Hop				10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John O'Boyle				14. MOTHER'S MAIDEN NAME Catherine Mahoney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 073-12-6298		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable cardiac arrhythmia DUE TO 416X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) rheumatic ht. disease & multivalvular involvement. DUE TO 32 yrs. (c) Chronic passive congestion with hepatic fibrosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic passive congestion with hepatic fibrosis							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Bethesda 14, Maryland				20g. (County) Bethesda 14, Maryland			
20h. (State) Bethesda 14, Maryland							
21. I certify that I attended the deceased from November 30, 1958 , to December 8, 1958 , that I last saw the deceased alive on December 8, 1958 , and that death occurred at 11:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William W. Pfaff M.D.				ADDRESS (Street, city or town, state) The Clinical Center			
PHYSICIAN'S NAME (Type) William W. Pfaff, M.D.				DATE SIGNED 12-8-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/9/58		22c. NAME OF CEMETERY OR CREMATORY St. Raymond	
22d. LOCATION (City, town, or county) Bronx, New York				(State) New York			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				ADDRESS Bethesda 14, Maryland		24a. REC'D BY REGISTRAR DEC 10 '58	
24b. REGISTRAR'S SIGNATURE Carl S. K...							

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CERTIFICATE OF DEATH

1901

NAME OF DECEASED: John C. Boyle

AGE: 65 YEARS

RESIDENCE: 110 W. 1st St. Baltimore, Md.

CAUSE OF DEATH: Stroke

DATE OF DEATH: September 30, 1901

PLACE OF DEATH: Home

SIGNATURE OF PHYSICIAN: John C. Boyle

DATE: Oct 11

PLACE: Baltimore, Md.

REGISTRATION NO.: 110-12-1208

THE CLERK OF THE COURT: The Clerk of the Court, Baltimore, Md.

DATE: Oct 11

PLACE: Baltimore, Md.

REGISTRATION NO.: 110-12-1208

THE CLERK OF THE COURT: The Clerk of the Court, Baltimore, Md.

DATE: Oct 11

PLACE: Baltimore, Md.

REGISTRATION NO.: 110-12-1208

14022

CERTIFICATE OF DEATH

Reg. Dist. No.

14001

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Mont. Co</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>14 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Ives Spring</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>				d. STREET ADDRESS <i>1917 - Rosemary Hill</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Samuel</i> Middle <i>O'Connell</i> Last <i>O'Connell</i>				4. DATE OF DEATH Month <i>Dec.</i> Day <i>9</i> Year <i>1958</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan. 31, 1881</i>		9. AGE (In years last birthday) <i>77 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired - Mining Engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self-employed</i>		11. BIRTHPLACE (State or foreign country) <i>Montana</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>O'Connell</i>				14. MOTHER'S MAIDEN NAME <i>Mary Sullivan</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>yes</i>		17. INFORMANT <i>John E. O'Connell - son.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PNEUMONIA, Left lower lobe</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>490X</i> (b) <i>Bronchiectasis</i> DUE TO (c) <i>Hypertensive Heart Disease</i> <i>10 yrs.</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>8 mos.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>CORONARY INSUFFICIENCY</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11/25</i> , 19 <i>58</i> , to <i>12/9</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>12/9</i> , 19 <i>58</i> , and that death occurred at <i>8:25</i> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>A. J. Brennan</i>				ADDRESS (Street, city or town, state) <i>Bethesda, Md.</i>			
PHYSICIAN'S NAME (Type) <i>A. J. BRENNAN</i>				DATE SIGNED <i>12/9/58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>12/11/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>GATE OF HEAVEN CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>MONTGOMERY COUNTY, MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>WARNER E. PUMPHREY, INC.</i> <i>Raymond A. Ziska</i>				ADDRESS <i>SILVER SPRING, MD.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kline</i>	
24a. REC'D BY REGISTRAR <i>DEC 12 '58</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13896 CERTIFICATE OF DEATH

14002

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nani</u> Middle <u>G.</u> Last <u>Owens</u>				4. DATE OF DEATH Month <u>12</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1868</u>		9. AGE (In years lost birthday) <u>90</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>8</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Thadus Green</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Blackburn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Margaret Hyson</u> Address <u>5410 McKinley St. Bethesda, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X Acute myocarditis</u> DUE TO <u>pneumonia, left lower lobe</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardio-vascular renal disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>52</u> , to <u>12-21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-20</u> , 19 <u>58</u> , and that death occurred at <u>6:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Roger Kuntz</u> M.D.				ADDRESS (Street, city or town, state) <u>371 Courthouse Rd. Bethesda, Md.</u> DATE SIGNED <u>12-21-58</u>			
PHYSICIAN'S NAME (Type) <u>C. Roger Kuntz, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-24-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kraus</u>	

14023

CERTIFICATE OF DEATH

14003

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Suburban Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 15.			
f. STREET ADDRESS 5611 Chevy Chase Parkway, N.W.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frank Middle Laurie Last Parisi				4. DATE OF DEATH Month December Day 17 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 22, 1917	
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months 41 Days 17 Hours 19 Min. 58		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Parisi		14. MOTHER'S MAIDEN NAME Katherine Roman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Jean Parisi		Address 5611 Chevy Chase Pkwy. Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic heart disease (c) ?				INTERVAL BETWEEN ONSET AND DEATH Immediate ? 2 wks. ? yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Unk.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Washington				20g. (County) D.C.		20h. (State) D.C.	
21. I certify that I attended the deceased from 12/12/58 to 12/17/58 , that I last saw the deceased alive on 12/16/58 , and that death occurred at 7:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Bernard J. Hays				ADDRESS (Street, city or town, state) 900-17th St. N.W. Wash. D.C.			
PHYSICIAN'S NAME (Type) The S.H. Hines Co				DATE SIGNED 12/17/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/19/58		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	
22d. LOCATION (City, town, or county) Washington, D.C.				22e. (State) D.C.		22f. (Country) U.S.A.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co				23a. REC'D BY REGISTRAR DEC 19 '58		23b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15.11.1982 Sunday 14/6 215
22.10.1982

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14024

CERTIFICATE OF DEATH

14004

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home for the Aged, Inc.		d. STREET ADDRESS 17 N. Lee St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERTA MARGARET PARKER First Middle Last		4. DATE OF DEATH Dec 9 1958 Month Day Year	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1880
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk in grocery store		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Fort Ashby, West Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel M. Parker		14. MOTHER'S MAIDEN NAME Margaret Reese	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-10-6988	
17. INFORMANT Asbury Methodist Home, Gaithersburg, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CONGESTIVE HEART FAILURE DUE TO (c) ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 12-7-58 128-58	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-28, 1958 , to 12-9, 1958 , that I last saw the deceased alive on 12-8, 1958 , and that death occurred at 8:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Sarah E. Glover		ADDRESS (Street, city or town, state) 10128 CEDAR LAKE KENSINGTON, MD DATE SIGNED 12-9-58	
PHYSICIAN'S NAME (Type) Sarah E. Glover			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-12-58	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. ADDRESS Gaithersburg, Md.		24a. REC'D BY REGISTRAR DEC 10 '58 24b. REGISTRAR'S SIGNATURE Arthur S. K...	

FOR STATE HEALTH DEPT.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
14025 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14005

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>7 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10412 Georgia Ave</u>			d. STREET ADDRESS <u>10412 Georgia Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Mary Veronica Payne</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>3</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/5/86</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>N. J.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>					
13. FATHER'S NAME <u>John Seemstine</u>			14. MOTHER'S MAIDEN NAME <u>Mary Hogan</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Pearl Johnson</u> Address <u>Stm 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> DUE TO <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Brosehart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-3-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosehart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/6/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER B. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 8 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14026

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Moorland Hills				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Moorland Hills			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5221 Farrington Road				d. STREET ADDRESS 5221 Farrington Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last AGNES C. POPKINS				4. DATE OF DEATH Month Day Year Dec 4 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 2, 1869	
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months 3 Days 2 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME John Wesley Hoges				14. MOTHER'S MAIDEN NAME Catherine E. Douglas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Florence E. Parks-Item# 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive heart disease DUE TO (c) Generalized arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 443X							
INTERVAL BETWEEN ONSET AND DEATH 3 weeks							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 1956 to present , that I last saw the deceased alive on Dec 4, 1958 , and that death occurred at 6:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4400-49 St NW Washington DC DATE SIGNED 12-4-58							
ACTUAL SIGNATURE C. P. Ryland M.D.							
PHYSICIAN'S NAME (Type) C. P. RYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/8/58		22c. NAME OF CEMETERY OR CREMATORY Glenwood		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE DEC 8 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kious	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14027

CERTIFICATE OF DEATH

Reg. Dist. No.

14007

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring,	c. LENGTH OF STAY IN 1b life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Sandy Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Lucy Middle Powell Last Powell		4. DATE OF DEATH Month Dec. Day 3 Year 1958	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/20/ 1872
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min.	IF UNDER 24 HRS. Months 86 Days 86 Hours 86 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William Powell	
14. MOTHER'S MAIDEN NAME Margaret Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Lucy Cook Brooke Rd., Sandy Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiorenal Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from May 3, 1936 , to Dec 3, 1958 , that I last saw the deceased alive on Dec. 3, 1958 , and that death occurred at 11:05 AM from the causes and on the date stated above.	
ACTUAL SIGNATURE Webster Sewell M.D.		ADDRESS (Street, city or town, state) Norbeck Rt.1 Silver Spring, Md.	
DATE SIGNED 12/6/58		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 12/7/58		22c. NAME OF CEMETERY OR CREMATORY Sandy Spring,	
22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden	
ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DEC 17 '58	
24b. REGISTRAR'S SIGNATURE Charles S. Harris			

Item 18 Film 237 12 31 58

13897

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Rockville c. LENGTH OF STAY IN 1b X Bethesda		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Schaefer-Walter Johnson Sr. High		d. STREET ADDRESS 6304 E. Halbert Road	
3. NAME OF DECEASED (Type or print) Jan Steven Rapke		4. DATE OF DEATH Month 12 / Day 1 / Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/13/42
9. AGE (In years last birthday) 16 1/2 yrs.		10. IF UNDER 1 YEAR Months 11 Days 8	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sidney Rapke		14. MOTHER'S MAIDEN NAME Eva Kraus	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Sidney Rapke - 6304 E. Halbert Rd., Beth., Md.	
17. INFORMANT Sidney Rapke		Address 6304 E. Halbert Rd., Beth., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial fragmentation DUE TO (c) ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Collapsed & died while playing basket ball at school			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 19		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. Broschert		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12-1-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 3, 1958	
22c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden		22d. LOCATION (City, town, or county) (State) Falls Church Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons-3501 14th St., N.W.		24a. REC'D BY REGISTRAR DEC 4 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, ONE IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13902



1. Name of deceased: _____

2. Age: _____

3. Sex: _____

4. Race: _____

5. Date of birth: _____

6. Date of death: _____

7. Place of death: _____

8. Cause of death: _____

9. Manner of death: _____

10. Signature of Medical Examiner: _____

11. Signature of Coroner: _____

12. Signature of Registrar: _____

13. Signature of Minister: _____

14. Signature of Justice: _____

15. Signature of Notary: _____

16. Signature of _____

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100. Signature of _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14028

CERTIFICATE OF DEATH

14009

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u>		c. LENGTH OF STAY IN 1b <u>X</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8 GRAFTON STREET</u>		d. STREET ADDRESS <u>18 GRAFTON STREET</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>RAVENEL</u> Last <u>RAVENEL</u>		4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 13, 1898</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>60</u> Days <u>28</u> Hours <u>19</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAWYER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SOUTH CAROLINA</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM DEC. RAVENEL</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH FITZSIMMONS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>579-01-9932</u>	
17. INFORMANT <u>JAMES P. NOLAN; 6 E. MELROSE ST.</u>		Address <u>Ch. Ch. MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA, BRONCHIOGENIC WITH METASTASES</u> <u>162.1</u> DUE TO <u>CEREBRAL + SPINAL</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>DUE TO</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 11</u> , 19 <u>58</u> , to <u>Dec 28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 28</u> , 19 <u>58</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leonard T. Peterson</u> M.D.		ADDRESS (Street, city or town, state) <u>8218 WISCONSIN AVE</u> DATE SIGNED <u>Bethesda Md</u>	
PHYSICIAN'S NAME (Type) <u>LEONARD T. PETERSON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/31/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Ft. MYER VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Lewis</u>		ADDRESS <u>1736 Pa. Av. NW</u>	
24a. REC'D BY REGISTRAR <u>DEC 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Fennell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G237 12-23-58 et
14029 CERTIFICATE OF DEATH

14010

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring Olney				c. LENGTH OF STAY IN 1b 3 wks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montg. Co. Gen. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lottie Middle Estelle Last Redmond				4. DATE OF DEATH Month Dec Day 12 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 28-1896	
9. AGE (In years last birthday) 62		10. AGE (In years last birthday) 62		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME George M. Howard				14. MOTHER'S MAIDEN NAME Levina Warner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Raymond Redmond, Clarksburg, Md				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis, recurrent 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized DUE TO (c) years.							INTERVAL BETWEEN ONSET AND DEATH 6 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1955 , to Dec. 13 , 1958, that I last saw the deceased alive on Dec. 12 , 1958, and that death occurred at 3:30 A. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Main Street DATE SIGNED							
ACTUAL SIGNATURE Gilcin F. Meadors, MD.				M.D. Damascus, Md.			
PHYSICIAN'S NAME (Type) Gilcin F. Meadors, MD.				ADDRESS Damascus, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/16/58		22c. NAME OF CEMETERY OR CREMATORY Neelsville		22d. LOCATION (City, town, or county) (State) Neelsville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Hilton's Funeral Home, Barnesville, Md Constance C. Hilton				24a. REC'D BY REGISTRAR DEC 17 58		24b. REGISTRAR'S SIGNATURE Arthur L. Brown	

11-11-19

NEWLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

11-11-19

NEWLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

1. Name of deceased: JOHN J. BROWN

2. Sex: Male

3. Age: 45

4. Date of birth: 1924-11-15

5. Place of birth: NEW YORK, N.Y.

6. Date of death: 1969-11-11

7. Place of death: NEW YORK, N.Y.

8. Cause of death: Heart Disease

9. Manner of death: Natural

10. Signature of physician: [Signature]

11. Signature of registrar: [Signature]

12. Date of registration: 1969-11-11

13. Place of registration: NEW YORK, N.Y.

14. Name of informant: [Name]

15. Address of informant: [Address]

16. Date of interview: [Date]

17. Name of informant: [Name]

18. Address of informant: [Address]

19. Date of interview: [Date]

20. Name of informant: [Name]

21. Address of informant: [Address]

22. Date of interview: [Date]

23. Name of informant: [Name]

24. Address of informant: [Address]

25. Date of interview: [Date]

26. Name of informant: [Name]

27. Address of informant: [Address]

28. Date of interview: [Date]

29. Name of informant: [Name]

30. Address of informant: [Address]

31. Date of interview: [Date]

32. Name of informant: [Name]

33. Address of informant: [Address]

34. Date of interview: [Date]

35. Name of informant: [Name]

36. Address of informant: [Address]

37. Date of interview: [Date]

38. Name of informant: [Name]

39. Address of informant: [Address]

40. Date of interview: [Date]

41. Name of informant: [Name]

42. Address of informant: [Address]

43. Date of interview: [Date]

44. Name of informant: [Name]

45. Address of informant: [Address]

46. Date of interview: [Date]

47. Name of informant: [Name]

48. Address of informant: [Address]

49. Date of interview: [Date]

50. Name of informant: [Name]

51. Address of informant: [Address]

52. Date of interview: [Date]

53. Name of informant: [Name]

54. Address of informant: [Address]

55. Date of interview: [Date]

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58. Date of interview: [Date]

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73. Date of interview: [Date]

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92. Name of informant: [Name]

93. Address of informant: [Address]

94. Date of interview: [Date]

95. Name of informant: [Name]

96. Address of informant: [Address]

97. Date of interview: [Date]

98. Name of informant: [Name]

99. Address of informant: [Address]

100. Date of interview: [Date]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14030

CERTIFICATE OF DEATH

14011

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 1 yr. 2 mons.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riva	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14511 Colesville Road (Marilea Rest Home)		d. STREET ADDRESS Box # 84		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THOMAS		First Middle Last ELANSING RESTER		4. DATE OF DEATH Month Day Year 10 Dec 10 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21st, 1880		9. AGE (In years last birthday) 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer--Self-Employed		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Miss.	
13. FATHER'S NAME William Rester		14. MOTHER'S MAIDEN NAME Annie Bilbo			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Mrs. Lona Mae Cotton, Riva, Anne Arundel Co. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331 X Arteriosclerotic heart disease DUE TO (b) Myocardial infarction DUE TO (c) Myocardial infarction Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from Dec 12, 1958 to Dec 10, 1958 , that I last saw the deceased alive on Dec 9, 1958 , and that death occurred at 9:54 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE John P. Rogers M.D. 1819 Landonway Rd, Silver Spring, Md PHYSICIAN'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Dec. 13th, 1958 22c. NAME OF CEMETERY OR CREMATORY Juniper Grove Church Cem. 22d. LOCATION (City, town, or county) (State) Poplarville, Miss. 23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md. 24a. REC'D BY REGISTRAR DATE DEC 15 '58 24b. REGISTRAR'S SIGNATURE Arthur L. Evans					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14031

CERTIFICATE OF DEATH

14012

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION #9 West Irving Street				e. STREET ADDRESS #9 West Irving Street			
3. NAME OF DECEASED (Type or print) First FANNY Middle OTIS Last RICHARDS				4. DATE OF DEATH Month December Day 12 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 23, 1868		9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months 8 Days 18	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME James Otis Bartlett				14. MOTHER'S MAIDEN NAME Olive Little Rogers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Bartlett Richards-son-same as 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/27 , 19 56 to 12/12 , 19 58 , that I last saw the deceased alive on 12/21 , 19 58 , and that death occurred at 11:25 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. L. Howell				ADDRESS (Street, city or town, state) Washington Clinic Wash 15 DC.			
PHYSICIAN'S NAME (Type) Wm. L. Howell				DATE SIGNED DEC 15 58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12/15/58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE DEC 18 58		24b. REGISTRAR'S SIGNATURE Arthur S. Proulx	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Robert A. Humphrey-Bernhardt, M.D.

Cincinnati 12/15/58

Cedar Hill

Eastland, Maryland

1. I certify that I have read the hospital record of the patient named above and that the patient has been discharged from the hospital in accordance with the medical advice of the attending physician.

2. I certify that the patient has been discharged from the hospital in accordance with the medical advice of the attending physician.

3. I certify that the patient has been discharged from the hospital in accordance with the medical advice of the attending physician.

4. I certify that the patient has been discharged from the hospital in accordance with the medical advice of the attending physician.

5. I certify that the patient has been discharged from the hospital in accordance with the medical advice of the attending physician.

6. I certify that the patient has been discharged from the hospital in accordance with the medical advice of the attending physician.

7. I certify that the patient has been discharged from the hospital in accordance with the medical advice of the attending physician.

8. I certify that the patient has been discharged from the hospital in accordance with the medical advice of the attending physician.

9. I certify that the patient has been discharged from the hospital in accordance with the medical advice of the attending physician.

10. I certify that the patient has been discharged from the hospital in accordance with the medical advice of the attending physician.

1. Name of patient		2. Date of birth		3. Sex		4. Race		5. Religion		6. Occupation		7. Address		8. City		9. State		10. Zip	
11. Name of physician		12. Date of admission		13. Date of discharge		14. Date of death		15. Cause of death		16. Place of death		17. Name of hospital		18. Name of attending physician		19. Name of certifying physician		20. Name of registrar	
21. Name of patient		22. Date of birth		23. Sex		24. Race		25. Religion		26. Occupation		27. Address		28. City		29. State		30. Zip	
31. Name of physician		32. Date of admission		33. Date of discharge		34. Date of death		35. Cause of death		36. Place of death		37. Name of hospital		38. Name of attending physician		39. Name of certifying physician		40. Name of registrar	

CERTIFICATE OF DEATH

MANITOWOC STATE HOSPITAL OF HEALTH - EASTLAND, MD

14032

Items 2,3 FilmG237 1-9-59 et

CERTIFICATE OF DEATH

14013

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck Dawsonville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradford's Rest Home		e. STREET ADDRESS c/o Dr. G. Poffenberger Silver Spring, Md. R. F. D. #1	
3. NAME OF DECEASED (Type or print) First William Middle P. Ballie Last Richmond		4. DATE OF DEATH Month December Day 6 Year 1958	
5. SEX male	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3, 1894
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Mebane, N. C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Zack Richmond		14. MOTHER'S MAIDEN NAME Elizabeth Williamson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Adeline Lloyd Address 1208 5th St., Durham, N. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Arteriosclerotic Cardiorenal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, cc2x (b) with Edema, Hypertension, Cardiac Asthma and Anuria. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Pulmonary Tuberculosis Inactive.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 3 , 1955, to Dec. 6 , 1958, that I last saw the deceased alive on Dec. 6 , 1958, and that death occurred at 10 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Webster Sewell M.D.		DATE SIGNED 12/8/58	
PHYSICIAN'S NAME (Type) Webster Sewell, M.D. Norbeck Rt. 1 Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/9/58	22c. NAME OF CEMETERY OR CREMATORY Lincoln Park	22d. LOCATION (City, town, or county) (State) Rockville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DEC 12 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14033

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4504 Chestnut Street				e. STREET ADDRESS 4504 Chestnut Street			
3. NAME OF DECEASED (Type or print) First IDA Middle SELMA Last RIEDEL				4. DATE OF DEATH Month Dec Day 3 Year 1958			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 Nov 1888	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Augusta Vogel				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Walter K. Riedel - Item# 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4340 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Kypho-scoliotic Heart Disease DUE TO (c) Kypho-scoliosis						INTERVAL BETWEEN ONSET AND DEATH 1 month 2 yrs congenital	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UREMIA							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Sept Day 30 Year 1958 Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 11134 Georgia Ave Silver Spring, Md.	
20f. (City or town) Red Bank, New Jersey				20g. (County) Red Bank, New Jersey			
20h. (State) Red Bank, New Jersey				20i. (City, town, or county) Red Bank, New Jersey			
21. I certify that I attended the deceased from Sept 1954 to 30 Dec 1958 , that I last saw the deceased alive on 1 Dec 1958 , and that death occurred at 1:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE M. L. White				DATE SIGNED 11/34 Dec 58			
PHYSICIAN'S NAME (Type) M. L. White				ADDRESS 11134 Georgia Ave., Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL, DISPOSITION Burial - Transit		22b. DATE THEREOF 12/4/58		22c. NAME OF CEMETERY OR CREMATORY Fairview		22d. LOCATION (City, town, or county) (State) Red Bank, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DEC 6 '58		24b. REGISTRAR'S SIGNATURE Robert A. Pumphrey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14015

14034

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington, D.C. b. COUNTY 47x-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home		d. STREET ADDRESS 4900 3rd St. N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LOUISE Peiffer First Middle Last		4. DATE OF DEATH December 25, 1958 Month Day Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/28/78
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Miamisburg, Ohio		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John R. Peiffer		14. MOTHER'S MAIDEN NAME Alice Fidler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hilary W. Costello, Colorado Building		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x Acute Cerebral Apoplexy DUE TO (probably cerebral artery thrombosis) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260x (b) Arteriosclerosis DUE TO Arterial Hypertension (c) Chronic		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① Diabetes Mellitus ② Hypertensive Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/17/58 , 19 58 , to 12/25/58 , that I last saw the deceased alive on 12/19/58 , 19 58 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. W. Dicklas		ADDRESS (Street, city or town, state) 4830 - 1 St. N.W. Wash. D.C.	
DATE SIGNED 12/25/58			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12/29/58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Ft. Myer, Va.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company		24a. REC'D BY REGISTRAR 2901 14th St. N.W. Washington 9, D.C.	
24b. REGISTRAR'S SIGNATURE DEC 29 '58			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14016

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington, Maryland		c. LENGTH OF STAY IN 1b 6 wks.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ruth V. Rodebaugh		4. DATE OF DEATH Month Dec. Day 24, Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 31, 1887
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 10 Days 23 Hours Min. 	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY Own Home	
12. BIRTHPLACE (State or foreign country) Berwick, Penna.		13. CITIZEN OF WHAT COUNTRY? U. S. A.	
14. FATHER'S NAME John W. Moorehead		15. MOTHER'S MAIDEN NAME Prisilla L. Shay	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		17. SOCIAL SECURITY NO. None	
18. INFORMANT Philip S. Moorehead,		Address 7708 Geranium St. Bethesda	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of both lungs DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma of breast DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 mo. 2 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1953 , to Dec 24 , 1958, that I last saw the deceased alive on Dec 21 , 1958, and that death occurred at 4:50 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stewart Clapp		ADDRESS (Street, city or town, state) 3921 Ingomar St. N.W. Wash 15 D.C.	
PHYSICIAN'S NAME (Type) Stewart Clapp		DATE SIGNED 12/24/58	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial-Transit 12-26-58 Westminster Ceme. Philadelphia, Penna.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey,		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE DEC 30 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



CERTIFICATE OF DEATH

14017

Reg. Dist. No.

14036

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. STREET ADDRESS <u>7702 Marbury Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Knowlton Rollins</u>				4. DATE OF DEATH Month Day Year <u>12 17 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 2, 1905</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>10 12</u>		IF UNDER 24 HRS. <u>53</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Radio Engineer F.C.C.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Minnesota</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>George Sherman Rollins</u>				14. MOTHER'S MAIDEN NAME <u>Helen Knowlton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Virginia Rollins Wife - Same</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse confluent pneumonia, both lungs</u> DUE TO <u>Pulmonary embolization</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ruptured Duodenal Ulcer</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Renal lithiasis</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 13</u> , 19 <u>57</u> , <u>December 17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>December 17</u> , 19 <u>58</u> , and that death occurred at <u>4:20 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Pumhrey</u>				DATE SIGNED <u>12/18/58</u>			
PHYSICIAN'S NAME (Type) <u>5009 Del Ray Avenue, Bethesda, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-22-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumhrey - Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD		CERTIFICATE OF DEATH	
<p>1. NAME OF DECEASED: <u>JOHN J. JONES</u></p> <p>2. SEX: <u>MALE</u></p> <p>3. AGE: <u>45</u></p> <p>4. DATE OF BIRTH: <u>1910</u></p> <p>5. PLACE OF BIRTH: <u>NEW YORK</u></p> <p>6. OCCUPATION: <u>CLERK</u></p> <p>7. MARITAL STATUS: <u>MARRIED</u></p> <p>8. EDUCATION: <u>HIGH SCHOOL</u></p> <p>9. RELIGION: <u>CATHOLIC</u></p> <p>10. RACE: <u>WHITE</u></p> <p>11. COLOR: <u>WHITE</u></p> <p>12. BUILD: <u>SLIM</u></p> <p>13. HAIR: <u>BROWN</u></p> <p>14. EYES: <u>BROWN</u></p> <p>15. SKIN: <u>Fair</u></p> <p>16. TALL: <u>5' 8"</u></p> <p>17. WEIGHT: <u>150</u></p> <p>18. BLOOD TYPE: <u>A</u></p> <p>19. TYPE OF DEATH: <u>NATURAL</u></p> <p>20. CAUSE OF DEATH: <u>HEART DISEASE</u></p> <p>21. PLACE OF DEATH: <u>HOME</u></p> <p>22. DATE OF DEATH: <u>1955</u></p> <p>23. TIME OF DEATH: <u>10:00 AM</u></p> <p>24. SIGNATURE OF DECEASED: <u>[Signature]</u></p> <p>25. SIGNATURE OF WITNESS: <u>[Signature]</u></p> <p>26. SIGNATURE OF PHYSICIAN: <u>[Signature]</u></p> <p>27. SIGNATURE OF CORONER: <u>[Signature]</u></p> <p>28. SIGNATURE OF JUDGE: <u>[Signature]</u></p> <p>29. SIGNATURE OF CLERK: <u>[Signature]</u></p> <p>30. SIGNATURE OF DECEASED'S NEAREST RELATIVE: <u>[Signature]</u></p> <p>31. SIGNATURE OF DECEASED'S NEXT OF KIN: <u>[Signature]</u></p> <p>32. SIGNATURE OF DECEASED'S ATTORNEY: <u>[Signature]</u></p> <p>33. SIGNATURE OF DECEASED'S MINISTER: <u>[Signature]</u></p> <p>34. SIGNATURE OF DECEASED'S CHURCH: <u>[Signature]</u></p> <p>35. SIGNATURE OF DECEASED'S FUNERAL HOME: <u>[Signature]</u></p> <p>36. SIGNATURE OF DECEASED'S BURIAL PLACE: <u>[Signature]</u></p> <p>37. SIGNATURE OF DECEASED'S CEMETERY: <u>[Signature]</u></p> <p>38. SIGNATURE OF DECEASED'S INTERMENT: <u>[Signature]</u></p> <p>39. SIGNATURE OF DECEASED'S CREMATION: <u>[Signature]</u></p> <p>40. SIGNATURE OF DECEASED'S OTHER: <u>[Signature]</u></p>		<p>41. NAME OF DECEASED: <u>JOHN J. JONES</u></p> <p>42. SEX: <u>MALE</u></p> <p>43. AGE: <u>45</u></p> <p>44. DATE OF BIRTH: <u>1910</u></p> <p>45. PLACE OF BIRTH: <u>NEW YORK</u></p> <p>46. OCCUPATION: <u>CLERK</u></p> <p>47. MARITAL STATUS: <u>MARRIED</u></p> <p>48. EDUCATION: <u>HIGH SCHOOL</u></p> <p>49. RELIGION: <u>CATHOLIC</u></p> <p>50. RACE: <u>WHITE</u></p> <p>51. COLOR: <u>WHITE</u></p> <p>52. BUILD: <u>SLIM</u></p> <p>53. HAIR: <u>BROWN</u></p> <p>54. EYES: <u>BROWN</u></p> <p>55. SKIN: <u>Fair</u></p> <p>56. TALL: <u>5' 8"</u></p> <p>57. WEIGHT: <u>150</u></p> <p>58. BLOOD TYPE: <u>A</u></p> <p>59. TYPE OF DEATH: <u>NATURAL</u></p> <p>60. CAUSE OF DEATH: <u>HEART DISEASE</u></p> <p>61. PLACE OF DEATH: <u>HOME</u></p> <p>62. DATE OF DEATH: <u>1955</u></p> <p>63. TIME OF DEATH: <u>10:00 AM</u></p> <p>64. SIGNATURE OF DECEASED: <u>[Signature]</u></p> <p>65. SIGNATURE OF WITNESS: <u>[Signature]</u></p> <p>66. SIGNATURE OF PHYSICIAN: <u>[Signature]</u></p> <p>67. SIGNATURE OF CORONER: <u>[Signature]</u></p> <p>68. SIGNATURE OF JUDGE: <u>[Signature]</u></p> <p>69. SIGNATURE OF CLERK: <u>[Signature]</u></p> <p>70. SIGNATURE OF DECEASED'S NEAREST RELATIVE: <u>[Signature]</u></p> <p>71. SIGNATURE OF DECEASED'S NEXT OF KIN: <u>[Signature]</u></p> <p>72. SIGNATURE OF DECEASED'S ATTORNEY: <u>[Signature]</u></p> <p>73. SIGNATURE OF DECEASED'S MINISTER: <u>[Signature]</u></p> <p>74. SIGNATURE OF DECEASED'S CHURCH: <u>[Signature]</u></p> <p>75. SIGNATURE OF DECEASED'S FUNERAL HOME: <u>[Signature]</u></p> <p>76. SIGNATURE OF DECEASED'S BURIAL PLACE: <u>[Signature]</u></p> <p>77. SIGNATURE OF DECEASED'S CEMETERY: <u>[Signature]</u></p> <p>78. SIGNATURE OF DECEASED'S INTERMENT: <u>[Signature]</u></p> <p>79. SIGNATURE OF DECEASED'S CREMATION: <u>[Signature]</u></p> <p>80. SIGNATURE OF DECEASED'S OTHER: <u>[Signature]</u></p>	

1. NAME OF DECEASED: JOHN J. JONES

2. SEX: MALE

3. AGE: 45

4. DATE OF BIRTH: 1910

5. PLACE OF BIRTH: NEW YORK

6. OCCUPATION: CLERK

7. MARITAL STATUS: MARRIED

8. EDUCATION: HIGH SCHOOL

9. RELIGION: CATHOLIC

10. RACE: WHITE

11. COLOR: WHITE

12. BUILD: SLIM

13. HAIR: BROWN

14. EYES: BROWN

15. SKIN: Fair

16. TALL: 5' 8"

17. WEIGHT: 150

18. BLOOD TYPE: A

19. TYPE OF DEATH: NATURAL

20. CAUSE OF DEATH: HEART DISEASE

21. PLACE OF DEATH: HOME

22. DATE OF DEATH: 1955

23. TIME OF DEATH: 10:00 AM

24. SIGNATURE OF DECEASED: [Signature]

25. SIGNATURE OF WITNESS: [Signature]

26. SIGNATURE OF PHYSICIAN: [Signature]

27. SIGNATURE OF CORONER: [Signature]

28. SIGNATURE OF JUDGE: [Signature]

29. SIGNATURE OF CLERK: [Signature]

30. SIGNATURE OF DECEASED'S NEAREST RELATIVE: [Signature]

31. SIGNATURE OF DECEASED'S NEXT OF KIN: [Signature]

32. SIGNATURE OF DECEASED'S ATTORNEY: [Signature]

33. SIGNATURE OF DECEASED'S MINISTER: [Signature]

34. SIGNATURE OF DECEASED'S CHURCH: [Signature]

35. SIGNATURE OF DECEASED'S FUNERAL HOME: [Signature]

36. SIGNATURE OF DECEASED'S BURIAL PLACE: [Signature]

37. SIGNATURE OF DECEASED'S CEMETERY: [Signature]

38. SIGNATURE OF DECEASED'S INTERMENT: [Signature]

39. SIGNATURE OF DECEASED'S CREMATION: [Signature]

40. SIGNATURE OF DECEASED'S OTHER: [Signature]

14037

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Florida</u> b. COUNTY <u>Miami (Broward)</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 16-22</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pompano Beach</u>	
c. LENGTH OF STAY IN lb <u>2 yrs</u>		d. STREET ADDRESS <u>4015 Washington St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5615 Newington Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John McKemie Roper</u>		f. DATE OF DEATH <u>Dec 9 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-8-1890</u>
9. AGE (In years last birthday) <u>68 yrs.</u>		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elect. Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u>	
11. BIRTHPLACE (State or foreign country) <u>S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wesley Roper</u>		14. MOTHER'S MAIDEN NAME <u>McCall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Edw. Roper (wife)</u>	
17. INFORMANT <u>Edw. Roper (wife)</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosehart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSEHART</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12/10/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 10 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

FOR STATE
HEALTH DEPT.

14037

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH
1908

NAME OF DECEASED
John Smith

No. 1

CAUSE OF DEATH
DISEASE

PLACE OF DEATH
HOME

AGE
45

RESIDENCE
Baltimore, Md.

Signature of Medical Examiner

Robert A. Humphrey-Bellenda, M.D.

Signature of Coroner

John Smith

14038

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pennsylvania</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Brownsville</u> <u>75 X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>R. D. #1</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <u>Anna</u> Middle <u>Marie</u> Last <u>Rymarchyk</u>		4. DATE OF DEATH		Month <u>December</u> Day <u>4</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 13, 1917</u>		9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Stephen Schwallon</u>				14. MOTHER'S MAIDEN NAME <u>Teresa Motickak</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>410X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rheumatic Heart Disease with mitral stenosis and insufficiency and tricuspid stenosis; Post-operative status.</u> (c) <u>operative status.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 2, 1958</u> , to <u>December 4, 1958</u> , that I last saw the deceased alive on <u>December 4, 1958</u> , and that death occurred at <u>12:10am</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>12/4/58</u> ACTUAL SIGNATURE <u>James A. McFarland</u> M.D. <u>National Institutes of Health</u> PHYSICIAN'S NAME (Type) <u>JAMES A. MCFARLAND, M. D.</u> <u>Bethesda 14, Maryland</u>							
22a. BURIAL, CREMATION, or other disposal <u>Burial</u>		22b. DATE THEREOF <u>12-4-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Catholic Cem. Brownsville, Penna.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Farnsworth</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1928

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

14039

CERTIFICATE OF DEATH

14020

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				d. STREET ADDRESS 3921 Ingomar St. N.W.			
3. NAME OF DECEASED (Type or print) First Middle Last Katherine W. SAMPSON				4. DATE OF DEATH Month Day Year DEC. 22 1958 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/22/92	
9. AGE (In years last birthday) 66 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Drs. Office		11. BIRTHPLACE (State or foreign country) San Antonio, Texas	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME A. A. Ware		14. MOTHER'S MAIDEN NAME Margaret L. Trotman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.3 Acute myelogenous leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Today	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1958 , to Dec. 22, 1958 , that I last saw the deceased alive on Dec 21, 1958 , and that death occurred at 11:30 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Stewart C. App				M.D. 3921 Ingomar St NW 12-22-58			
PHYSICIAN'S NAME (Type) Stewart C. App				ADDRESS (Street, city or town, state) Washington 15 D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/24/58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Cherry Chase Funeral Home				24a. REC'D BY REGISTRAR 5103 Wisconsin Ave Washington DC		24b. REGISTRAR'S SIGNATURE DATE DEC 29 '58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10038

MASSACHUSETTS DEPARTMENT OF HEALTH-BATTLING 18

Page 1018 100

<p>1. NAME OF DECEASED JOHN J. BROWN</p>		<p>2. SEX MALE</p>	
<p>3. AGE 65</p>		<p>4. DATE OF BIRTH 1873</p>	
<p>5. PLACE OF BIRTH BOSTON, MASS.</p>		<p>6. OCCUPATION LABORER</p>	
<p>7. MARITAL STATUS MARRIED</p>		<p>8. DATE OF MARRIAGE 1900</p>	
<p>9. NAME OF SPOUSE MARY J. BROWN</p>		<p>10. DATE OF DEATH 1938</p>	
<p>11. PLACE OF DEATH BOSTON, MASS.</p>		<p>12. CAUSE OF DEATH HEART DISEASE</p>	
<p>13. MEDICAL HISTORY HYPERTENSION</p>		<p>14. SIGNATURE OF PHYSICIAN DR. J. H. SMITH</p>	
<p>15. SIGNATURE OF REGISTRAR J. H. SMITH</p>		<p>16. DATE OF REGISTRATION 1938</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13884

CERTIFICATE OF DEATH

14021

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
c. LENGTH OF STAY IN 1b <u>17 days</u>				d. STREET ADDRESS <u>Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MILDRED MAX Schaefer</u>				4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-31-99</u>		9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>3</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Takoma Park Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John H. Schaefer</u>				14. MOTHER'S MAIDEN NAME <u>May West</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>pt Hospital record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Grand seizure - probably occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis, chronic c. congestive heart failure</u> (c) <u>fatigue</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u> <u>Diabetes Mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>refuse</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/11/58</u> , 19 <u>58</u> , to <u>12/28/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/28/58</u> , 19 <u>58</u> , and that death occurred at <u>1:30</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas H Wolohun</u> M.D.				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave Takoma Park MD</u>			
PHYSICIAN'S NAME (Type) <u>Chas H Wolohun</u>				DATE SIGNED <u></u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Dec 31, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Frank</u> ADDRESS <u>WASH DC 254 Carroll St NW</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

14040

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 152 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ West Hyattsville 1615, 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 3419 Rutgers Street			
3. NAME OF DECEASED (Type or print) First James Middle Allen Last Schuler				4. DATE OF DEATH Month December Day 14 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1953		9. AGE (In years last birthday) yrs. 5	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Willis K. Schuler				14. MOTHER'S MAIDEN NAME Pearl V. Mockabee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal failure DUE TO (c) Subacute glomerular nephritis INTERVAL BETWEEN ONSET AND DEATH 3 days months 1 year						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 15 , 19 58 , to December 14 , 19 58 , that I last saw the deceased alive on December 14 , 19 58 , and that death occurred at 9:46 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/15/58 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE John A. Oates, Jr., M.D.		PHYSICIAN'S NAME (Type) John A. Oates, Jr., M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company—Washington, D.C.				24a. REC'D BY REGISTRAR DEC 17 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
14041 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14023

Reg. Dist. No.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 10 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8908 Penna. Ave.				d. STREET ADDRESS 8908 Penna. Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hilda Wright Scott				4. DATE OF DEATH Month 12/27/58 Day 19			
5. SEX female	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/1903		9. AGE (In years last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George Wright			14. MOTHER'S MAIDEN NAME Irene Brown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Geraldine Jackson 216 Gallatin St. NW. Wash. D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12/27/58			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12/31/58		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion,		22d. LOCATION (City, town, or county) (State) Silver Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Suroden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE JAN 5 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Travis			

14042

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN 1b WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) KENSINGTON GARDENS SANITARIUM		d. STREET ADDRESS 2701 CONN. AVE., N.W.	
3. NAME OF DECEASED (Type or print) First C. Middle MELVIN Last SHARPE		4. DATE OF DEATH Month DEC. Day 25 , 1958 Year 19	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 12, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
13. FATHER'S NAME GEORGE H. SHARP		14. MOTHER'S MAIDEN NAME ELIZABETH MELVIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 537-09-3694	
17. INFORMANT GORDON SHARPE, 4619 SEDGEWICK ST., N.W., D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Angina, pulmonary embolism DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 493X (b) CVA (c) arteriosclerosis; hypercholesterolemia		INTERVAL BETWEEN ONSET AND DEATH 36 hours 72 hours 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 1950, to 25-Dec , 1958, that I last saw the deceased alive on 24-Dec , 1958, and that death occurred at 1:08 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE George W. Reeves M.D.		ADDRESS (Street, city or town, state) 1746 K St. N.W. Wash. D.C. 20004	
PHYSICIAN'S NAME (Type) George W. Reeves		DATE SIGNED 1746 K ST., N.W., WASH., D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12/29/58	22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEM.	22d. LOCATION (City, town, or county) (State) WASHINGTON, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Pawlowski, 1756 Pa. Ave., N.W.		24. REC'D BY REGISTRAR DATE DEC 30 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14043

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montg. Co. General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>OLIVER</u> Last <u>SHAW</u>		4. DATE OF DEATH Month <u>December</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 17, 1913</u>
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>20</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Ollie Meade Shaw</u>		14. MOTHER'S MAIDEN NAME <u>Elsie Rebecca Crown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>WW 2</u>	
17. INFORMANT <u>Georgia Lee Shaw -wife-same as 2d</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fatty Embolism</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 4</u> , 19 <u>58</u> , to <u>Dec. 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec. 7</u> , 19 <u>58</u> , and that death occurred at <u>5:45</u> p. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jack Schumacher</u>		DATE SIGNED <u>Dec. 12-7-58</u>	
PHYSICIAN'S NAME (Type) <u>Jack Schumacher</u>		<u>Gaithersburg, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/10/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Derwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Derwood, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>DEC 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

George J. Gibson
Municipal Light House
Fatty Embolism

14044 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN lb 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 4516 Alton Place, NW			
3. NAME OF DECEASED (Type or print) First Bernard Middle Paul Last Sheehy				4. DATE OF DEATH Month December Day 12 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1909	9. AGE (In years last birthday) yrs. 49	IF UNDER 1 YEAR Months 47 Days X Hours 3	IF UNDER 24 HRS. Months 47 Days X Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done (most of working life, even if retired)) Stock Room Foreman		10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Sheehy				14. MOTHER'S MAIDEN NAME Hannah Walsh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 578-09-9360		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TRACHEAL OBSTRUCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF TONGUE & MOUTH DUE TO METASTATIC (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5 MIN. 1 YEAR	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 9, 19 58 , to December 12, 19 58 , that I last saw the deceased alive on December 12, 19 58 , and that death occurred at 8:35 p.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Theodore L. Goodfriend M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/13/58			
PHYSICIAN'S NAME (Type) THEODORE L. GOODFRIEND, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-15-1958		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		22d. LOCATION (City, town, or county) (State) MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Timothy Hanlon ADDRESS 3830 Ga. Ave. N.W. DC				24a. REC'D BY REGISTRAR DATE DEC 29 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 12
1902
CERTIFICATE OF DEATH

12-12-1902 DATE OF DEATH

Twenty Years 3000 Dr. C. C. H. M.

W. H. H. M.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14045

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14027

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown (rural)	c. LENGTH OF STAY IN 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Germantown (rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Seneca Road		d. STREET ADDRESS Berryville Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Alfred Middle Edward Last Smith		4. DATE OF DEATH Month Dec Day 22 Year 1958	
5. SEX male	6. COLOR OR RACE ool.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/16
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Smith	
14. MOTHER'S MAIDEN NAME Jewel Duffin		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Dorothy V. Smith Address Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of skull, crushed chest & pelvis and 825X DUE TO Multiple Injuries, extreme Auto Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was driver of car involved in accident		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>	
22a. TIME OF INJURY Month, Day, Year 9:28 a.m. 12/22/58		22b. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway		22d. (City or town) (County) (State) Germantown (rural) montg. Md.	
23. ACTUAL SIGNATURE Frank J. Broschart M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Frank J. Broschart ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/22/58			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE THEREOF 12/26/58	
24c. NAME OF CEMETERY OR CREMATORY Lincoln Park.,		24d. LOCATION (City, town, or county) (State) Rockville, Md.	
24e. FUNERAL DIRECTOR'S SIGNATURE Robert L. Surdick ADDRESS Rockville, Md.		24f. REC'D BY REGISTRAR DEC 30 '58	
24g. REGISTRAR'S SIGNATURE Arthur S. Kraus			

14046

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 3½ yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 5211 Locust Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) 5211 Locust Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Carrie T. Smith		4. DATE OF DEATH Month Day Year 12-29-58 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-25-1867
9. AGE (In years last birthday) 91		IF UNDER 1 YEAR Month Days Hours Min. 10 4	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elias Stottlemeyer		14. MOTHER'S MAIDEN NAME Eliza ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mark O. Smith - Son - Same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary congestion, acute 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) congestive heart failure, acute DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs. 12 hrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct , 19 58 , to 29 Dec , 19 58 , that I last saw the deceased alive on 29 Dec , 19 58 , and that death occurred at 4:25 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7659 Old Georgetown Rd. Bethesda, Maryland DATE SIGNED 12/29/58			
ACTUAL SIGNATURE John M. Wyman		M.D. 7659 Old Georgetown Rd. Bethesda, Maryland	
PHYSICIAN'S NAME (Type) John M. Wyman, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/31/58	22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery	22d. LOCATION (City, town, or county) (State) Smithsburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pimphrey, Bethesda, Md.		24a. REC'D BY REGISTRAR DATE JAN 2 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Klaus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

14047

14029

14047

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 5 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Laurel 16.41.2		d. STREET ADDRESS 811 Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nancy Middle Eileen Last SMITH		4. DATE OF DEATH Month December Day 13 Year 19 58		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1-27-56		9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months 2		IF UNDER 24 HRS. Days 13 Hours 19 Min. 58		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Hugh Melvin SMITH		14. MOTHER'S MAIDEN NAME Mary CLARK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Official Navy Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) intercranial hemorrhage 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) acute leukemia DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 6 mos.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		21. I certify that I attended the deceased from December 5, 1958 , to December 13, 1958 , that I last saw the deceased alive on December 13, 1958 , and that death occurred at 5:30A M. from the causes and on the date stated above		ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC DATE SIGNED 12-13-58	
ACTUAL SIGNATURE Howard A. Pearson		M.D. U. S. Naval Hospital, NNMC		PHYSICIAN'S NAME (Type) Howard A. PEARSON, LT, MC, USN		Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-17-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE DEC 17 58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13885 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14030

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park D.O.A.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>			d. STREET ADDRESS <u>8029 Eastern Ave.</u>		
3. NAME OF DECEASED (Type or print) <u>Jacob (W.M.W.) Solomon</u>			4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1958</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>4-6-93</u>		9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>14</u> Hours <u>19</u> Min. <u>58</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		12. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		13. BIRTHPLACE (State or foreign country) <u>England</u>	
14. FATHER'S NAME <u>David Solomon</u>		15. MOTHER'S MAIDEN NAME <u>Rose Beers</u>		16. CITIZEN OF WHAT COUNTRY? <u>America</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		18. SOCIAL SECURITY NO. <u>—</u>		19. INFORMANT Address <u>Mrs. Jessie Solomon - Wife - same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-14-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 15, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial Garden - Falls Church Va.</u>	
22d. LOCATION (City, town, or county) (State)		22e. REC'D BY REGISTRAR <u>Bernard Danzansky & Sons - 3501-14 St. N.W.</u>			
22f. REGISTRAR'S SIGNATURE		22g. DATE <u>DEC 17 '58</u>			

FOR STATE
DEATH CERT.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE
123456 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED
IN FULL

DATE OF DEATH

PLACE OF DEATH
IN FULL

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

OTHER

DETAILS

OF DEATH

IN FULL

DATE OF DEATH

IN FULL

DATE OF DEATH

IN FULL

DATE OF DEATH

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14048

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u>				d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4900 Battery La. apt 402</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				f. STREET ADDRESS <u>4900 Battery La</u>			
3. NAME OF DECEASED (Type or print) <u>Marshall</u> First <u>Spencer</u> Middle <u>Lee</u> Last				4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-1-31</u>	
9. AGE (In years last birthday) <u>27</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>14</u>		IF UNDER 24 HRS. Hours <u>14</u> Min. <u>00</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>			
11. BIRTHPLACE (State or foreign country) <u>DC.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Marshall Spencer</u>				14. MOTHER'S MAIDEN NAME <u>Marguerite Browning</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>USAF</u>				16. SOCIAL SECURITY NO. <u>577-38-716</u>			
17. INFORMANT <u>Nephew</u> Address <u>Alfred Browning - 35 E. St. N.W., Wash. DC</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Increased Intracranial Pressure</u> 331X DUE TO <u>Intraventricular Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intracerebral Hemorrhage</u> (c) <u>Intracerebral Hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-16-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 19, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 19 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CHURCH		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF BURIAL PLACE		20. SIGNATURE OF INTERMENT		21. SIGNATURE OF RECORDS	
22. SIGNATURE OF VITALS		23. SIGNATURE OF DEATH		24. SIGNATURE OF CERTIFICATE	
25. SIGNATURE OF DEATH		26. SIGNATURE OF DEATH		27. SIGNATURE OF DEATH	
28. SIGNATURE OF DEATH		29. SIGNATURE OF DEATH		30. SIGNATURE OF DEATH	
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49. SIGNATURE OF DEATH		50. SIGNATURE OF DEATH		51. SIGNATURE OF DEATH	
52. SIGNATURE OF DEATH		53. SIGNATURE OF DEATH		54. SIGNATURE OF DEATH	
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58. SIGNATURE OF DEATH		59. SIGNATURE OF DEATH		60. SIGNATURE OF DEATH	
61. SIGNATURE OF DEATH		62. SIGNATURE OF DEATH		63. SIGNATURE OF DEATH	
64. SIGNATURE OF DEATH		65. SIGNATURE OF DEATH		66. SIGNATURE OF DEATH	
67. SIGNATURE OF DEATH		68. SIGNATURE OF DEATH		69. SIGNATURE OF DEATH	
70. SIGNATURE OF DEATH		71. SIGNATURE OF DEATH		72. SIGNATURE OF DEATH	
73. SIGNATURE OF DEATH		74. SIGNATURE OF DEATH		75. SIGNATURE OF DEATH	
76. SIGNATURE OF DEATH		77. SIGNATURE OF DEATH		78. SIGNATURE OF DEATH	
79. SIGNATURE OF DEATH		80. SIGNATURE OF DEATH		81. SIGNATURE OF DEATH	
82. SIGNATURE OF DEATH		83. SIGNATURE OF DEATH		84. SIGNATURE OF DEATH	
85. SIGNATURE OF DEATH		86. SIGNATURE OF DEATH		87. SIGNATURE OF DEATH	
88. SIGNATURE OF DEATH		89. SIGNATURE OF DEATH		90. SIGNATURE OF DEATH	
91. SIGNATURE OF DEATH		92. SIGNATURE OF DEATH		93. SIGNATURE OF DEATH	
94. SIGNATURE OF DEATH		95. SIGNATURE OF DEATH		96. SIGNATURE OF DEATH	
97. SIGNATURE OF DEATH		98. SIGNATURE OF DEATH		99. SIGNATURE OF DEATH	
100. SIGNATURE OF DEATH		101. SIGNATURE OF DEATH		102. SIGNATURE OF DEATH	

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14032

13886

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 77 Takoma Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Erickson Nursing Home		d. STREET ADDRESS 7300 Baltimore Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GERTRUDE Middle STERN Last STERN		4. DATE OF DEATH Month December Day 23 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1869
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Govt. Empl.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Simon Stern		14. MOTHER'S MAIDEN NAME Betty Katz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Sol Rosenblatt-3410 Broad Branch Terr., NW		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized atherosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 days 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 19, 1958 to Dec 23, 1958 , that I last saw the deceased alive on Dec 21, 1958 , and that death occurred at 4 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Morris H. Rosenberg M.D. 2025 Eye St NW. Wash. D.C. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 24, 1958	
22c. NAME OF CEMETERY OR CREMATORY Washington Hebrew Cong. Cem. Washington		22d. LOCATION (City, town, or county) (State) D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons-3501 14th St., N.W.		24a. REC'D BY REGISTRAR DATE DEC 29 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14033

14049

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>2 wks.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		d. STREET ADDRESS <u>114905 Cokesville Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Carl</u> First <u>George</u> Middle <u>Sterzer</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 4, 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery Products Co. Wash., D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Sterzer</u>		14. MOTHER'S MAIDEN NAME <u>Amalia Ruppel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Hosp. Records & Wife.</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>451X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Disssecting aneurysm, aorta</u> (c) <u>Hypertensive cardio-vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 min.</u> <u>4 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>54</u> , to <u>Dec</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 12</u> , 19 <u>58</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>J. D. Bonifant</u> M.D. <u>Silver Spring Md. 12/30/58</u> PHYSICIAN'S NAME (Type) <u>DEMENT BONIFANT</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>1/2/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DATE 2 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES EARL RAY		M		35		12-1-28		MOBILE, ALABAMA		LABORER		SINGLE		WHITE	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
4-4-68		10:00 AM		ST. LOUIS, MISSOURI		HEART DISEASE		NATURAL		[Signature]		[Signature]		[Signature]	
17. COUNTY		18. CITY		19. STATE		20. ZIP CODE		21. HOSPITAL		22. PHYSICIAN		23. REGISTRAR		24. WITNESSES	
ST. LOUIS		ST. LOUIS		MISSOURI		63101		ST. LOUIS		DR. J. H. [Signature]		[Signature]		[Signature]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

13887

CERTIFICATE OF DEATH

Reg. Dist. No.

14034

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>D.C.</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hospital</i>				d. STREET ADDRESS <i>834 Xenia St. S.E.</i>			
3. NAME OF DECEASED (Type or print) First <i>Nell</i> Middle <i>Kathleen</i> Last <i>Swaban</i>				4. DATE OF DEATH Month <i>12</i> - Day <i>16</i> Year <i>1958</i>			
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-5-1902</i>	9. AGE (In years lost birthday) <i>56</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Adam Gorman</i>				14. MOTHER'S MAIDEN NAME <i>Helen Gustaitis</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Husband. & Hosp. Records.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Disease</i> DUE TO <i>Stroke (CVA)</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Stroke (CVA)</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> <i>4 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>June</i> , 1956, to <i>Dec 16</i> , 1958, that I last saw the deceased alive on <i>Dec 16</i> , 1958, and that death occurred at <i>11:00 A.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>W.B.W. Ardorp M.D.</i>				ADDRESS (Street, city or town, state) <i>837 Bonifant St. Silver Spring, Md.</i>			
DATE SIGNED <i>12/16/58</i>							
PHYSICIAN'S NAME (Type) <i>W.B.W. ARDORP</i>				ADDRESS <i>837 Bonifant St. Silver Spring, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>12-19-58</i>		<i>Arlington Hall</i>		<i>2 X Myer, Va</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert Mattingly</i>				ADDRESS <i>13 E. 1st St. W. DC 20</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 19 '58</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3

14050

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> 47x-3			
c. LENGTH OF STAY IN 1b <u>30 days</u>				d. STREET ADDRESS <u>5104 12th Street, NE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <u>Blanche</u> Middle <u>Beatrice</u> Last <u>Swann</u>		4. DATE OF DEATH		Month <u>December</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15, 1908</u>	9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Robert Ward</u>				14. MOTHER'S MAIDEN NAME <u>Georgia Montgomery</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unascertainable</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Md.</u>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anemia</u> DUE TO <u>Carcinoma of the Stomach with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastasis to bone marrow</u> DUE TO (c) <u>Metastasis to bone marrow</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>? 4 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 26, 1958</u> , to <u>December 26, 1958</u> , that I last saw the deceased alive on <u>December 26, 1958</u> , and that death occurred at <u>2:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert C. Hoye</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>12/27/58</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT C. HOYE, M.D.</u>				National Institutes of Health <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-31-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN T. RHINES</u>				ADDRESS <u>3015 12th St. NE</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 30 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE AT BIRTH

SEX AT BIRTH

RACE AT BIRTH

EDUCATION AT BIRTH

OCCUPATION AT BIRTH

RELIGION AT BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE AT BIRTH

SEX AT BIRTH

RACE AT BIRTH

EDUCATION AT BIRTH

OCCUPATION AT BIRTH

RELIGION AT BIRTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14051

CERTIFICATE OF DEATH

Reg. Dist. No.

14036

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C. 47x-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fairland Nursing Home		d. STREET ADDRESS 1603 Monroe St. N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Edna Last Taylor		4. DATE OF DEATH Month Dec Day 18 , Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/21/90
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min.	IF UNDER 24 HRS. Months 68 Days 68 Hours 68 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Conn.	
11. BIRTHPLACE (State or foreign country) Conn.		12. CITIZEN OF WHAT COUNTRY? Conn.	
13. FATHER'S NAME ---Fox		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Frances E. Taylor	
17. INFORMANT same as #2		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Subarachnoid Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Heart Disease DUE TO Coronary atherosclerotic Heart DUE TO Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 9 yrs 9 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-19 , 19 58 , to 12-18 , 19 58 , that I last saw the deceased alive on Dec 11 , 19 58 , and that death occurred at 3 PM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 1118 17th St NW DC 5 DATE SIGNED Dec 18 1958	
ACTUAL SIGNATURE Benjamin Manchester		M.D. Benjamin Manchester	
PHYSICIAN'S NAME (Type) BENJAMIN MANCHESTER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/22/58	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company		24a. REC'D BY REGISTRAR 2901 14th St. N.W. Washington, 9, D.C.	
24b. REGISTRAR'S SIGNATURE 22 Dec 22 '58		24c. REGISTRAR'S SIGNATURE William L. Hines	

14052

CERTIFICATE OF DEATH

Reg. Dist. No.

14037

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3			
c. LENGTH OF STAY IN 1b <u>4 days</u>				d. STREET ADDRESS <u>1114 East Capitol Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>S</u> Last <u>Thaxton</u>				4. DATE OF DEATH Month <u>December</u> Day <u>25</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>9/20/97</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Annex</u>		11. BIRTHPLACE (State or foreign country) <u>Mississippi</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Dennis Smyly</u>				14. MOTHER'S MAIDEN NAME <u>Jessie Ailene McCombe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>424-10-8303</u>		17. INFORMANT <u>Anna V. Schuldt</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA, TRANSVERSE COLON</u> <u>1581</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-20</u> , 19 <u>58</u> , to <u>12-25</u> , 19 <u>58</u> that I last saw the deceased alive on <u>12-24</u> , 19 <u>58</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above. Philip R. James M.D. <u>Washington Clinic</u> ADDRESS (Street, city or town, state) DATE SIGNED PHYSICIAN'S NAME (Type) <u>Philip R. James</u> <u>Weston Ave. St. Wisconsin D.V. b.e</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>DEC. 29-58</u>		<u>Forest Hill Cemetery</u>		<u>Birmingham, Alabama</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u> ADDRESS <u>603 11th St. SE.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 29 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Carol L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14053 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
f. STREET ADDRESS <u>4601 DeRussey Pkwy</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Amy</u> Middle <u>-</u> Last <u>Tolley</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/20/94</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>24</u>		IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Mosley England</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>James Holliday</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Clegg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-38-3558</u>		17. INFORMANT <u>Arnold Tolley, 4601 DeRussey Pkwy, Chevy Chase 15</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, recurrent</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u> DUE TO (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>-</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12/17</u> , 19 <u>57</u> , to <u>12/14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/14</u> , 19 <u>58</u> , and that death occurred at <u>6:00 p.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6306 Wisconsin Ave Chevy Chase, Md</u> DATE SIGNED <u>-</u>							
ACTUAL SIGNATURE <u>I. L. Marks</u>				M.D. <u>6306 Wisconsin Ave Chevy Chase, Md</u>			
PHYSICIAN'S NAME (Type) <u>I. L. Marks</u>				ADDRESS <u>6306 Wisconsin Avenue, Chevy Chase, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/17/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fries</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14054

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 18 days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY New York c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York d. STREET ADDRESS 25 South Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) James Roy Townsend, Jr.				4. DATE OF DEATH Month December Day 18 Year 1958								
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 10, 1924		9. AGE (In years last birthday) yrs. 34		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Townsend, Sr.				14. MOTHER'S MAIDEN NAME Clara Pedtke								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 330-14-1480		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Operative hemorrhage 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic stenosis, congenital DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 20 min Life												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
MEDICAL CERTIFICATION												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from November 30, 1958 , to December 18, 1958 , that I last saw the deceased alive on December 18, 1958 , and that death occurred at 2:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/19/58 The National Institutes of Health Bethesda 14, Maryland												
ACTUAL SIGNATURE James A. McFarland M.D.				PHYSICIAN'S NAME (Type) JAMES A. MCFARLAND, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 12/20/58		22c. NAME OF CEMETERY OR CREMATORY Wash, D.C.		22d. LOCATION (City, town, or county) (State) New York, N.Y.				
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.				ADDRESS 1400 Chapin St		24a. REC'D BY REGISTRAR DEC 24 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass				

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14040

14055

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY Port Royal d. STREET ADDRESS Box 142 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alan Middle Joseph Last TUBOLINO		4. DATE OF DEATH Month December Day 7 Year 19 58	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-58
9. AGE (In years last birthday) 3		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph M. TUBOLINO		14. MOTHER'S MAIDEN NAME Margaret (n) GLESLIA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Joseph M. Tubolino (Father) SSGT USMC		Address Box 142 Port Royal, S.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital heart disease DUE TO (c) Aortic - pulmonary embolism		INTERVAL BETWEEN ONSET AND DEATH 5 wks 3 mo 3 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 4, 1958 , to December 7, 1958 , that I last saw the deceased alive on December 7, 1958 , and that death occurred at 0130A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC DATE SIGNED 12-8-58			
ACTUAL SIGNATURE F. DE PAOLA		PHYSICIAN'S NAME (Type) F. DE PAOLA, LCDR, MC, USN Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-9-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. PUMPHREY		24a. REC'D BY REGISTRAR DEC 10 1958	
ADDRESS 3557 Wisconsin Ave, Bethesda		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

1900

THE DEPT. OF HEALTH

BOYD, JAMES

DECEASED

WHITE

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13888

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK, MD.</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM + HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>VESTA</u> Middle <u>MILDRED</u> Last <u>TUCKER</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>FE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/17/17</u>	
9. AGE (In years lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Statistical WORK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. of Defense</u>		11. BIRTHPLACE (State or foreign country) <u>MICHIGAN</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>ARTHUR TUCKER</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA WIND OVER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-32-2706</u>		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Shock</u> <u>782.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Heart Failure</u> DUE TO (c) <u>Ventricular Tachycardia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-30</u> , 19 <u>58</u> , to <u>12-3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-2-58</u> , 19 <u>58</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard L. Clapp</u> M.D.				ADDRESS (Street, city or town, state) <u>7600 Carroll Hile, Takoma Park, Maryland</u>		DATE SIGNED <u>12-3-58</u>	
PHYSICIAN'S NAME (Type) <u>Richard L. Clapp</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12/5/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>				ADDRESS <u>2901-1445 N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 4 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14056

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Malcolm K. Varnell</u>				4. DATE OF DEATH Month Day Year <u>12 18 19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/9/81</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Attorney</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Malcolm K. Varnell</u>				14. MOTHER'S MAIDEN NAME <u>Lola Von Friedenthahl</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>593 X Arterio-sclerotic Heart Disease</u> DUE TO (b) <u>Arterio-sclerosis</u> DUE TO (c) <u>Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3222 alcoholism</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/1</u> 19 <u>57</u> to <u>12/18</u> 19 <u>58</u> , that I last saw the deceased alive on <u>12/17/58</u> , 19 <u>58</u> , and that death occurred at <u>7:47 a.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. W. Bird</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Sandy Spring, Md. 12/18/58</u>			
PHYSICIAN'S NAME (Type) <u>J. W. Bird, M. D.</u>				Sandy Spring, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/20/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co.</u> ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BATHING ONE 10

DATE OF DEATH

RESIDENT

DECEASED

AGE

SEX

CAUSE OF DEATH

PLACE OF DEATH

IN

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14057 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14043

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Md	c. LENGTH OF STAY IN lb 2 Hours	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River 18x-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. NAVAL HOSPITAL, NETHE		d. STREET ADDRESS MOQ, NAS,	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Hedwigg Hedwige Irene Via	4. DATE OF DEATH Month 12 Day 31 Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-3-22
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Canada
12. CITIZEN OF WHAT COUNTRY? USA Canadian			
13. FATHER'S NAME J. Albert Manseau		14. MOTHER'S MAIDEN NAME Isabelle Manseau	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) Fracture, Skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operator of auto that was involved in head on collision			INTERVAL BETWEEN ONSET AND DEATH 6 Hours
20c. TIME OF INJURY Month, Day, Year Hour 4 p. m. 12 31 19 58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) (County) (State) Leonardtown, St Marys Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-6-59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James L. Cunningham		24a. REC'D BY REGISTRAR JAN 5 1959	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		24c. ADDRESS Ives Funeral Home, 2847 Wilson, Blvd. Arlington, Va.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14044

14058

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>2 1/2 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>605 Univ. Blvd. E</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York</u> 69 X-3 d. STREET ADDRESS <u>610 W 163rd St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Morris</u> Victor First Middle Last 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-2-1882</u> 9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				4. DATE OF DEATH <u>12-23-1958</u> Month Day Year			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Industrial brushes</u> 11. BIRTHPLACE (State or foreign country) <u>Romania</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>10-07-3300</u> 17. INFORMANT <u>Rita Dorotina (daughter)</u> Address <u>Item 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12-23-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/26/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westchester County, N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Pumphrey, Inc.</u> ADDRESS <u>Silver Spring, MD.</u>				24a. REC'D BY REGISTRAR <u>DEC 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 215

14059

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Spotsylvania 83x-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Box 102, Rt. 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Caroline Louise WABBLE			4. DATE OF DEATH Month Day Year December 5 1958				
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-3-85	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Mass.			
13. FATHER'S NAME James WHITE			14. MOTHER'S MAIDEN NAME Emma COLE				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (S-I-L) Mrs. Grace E. Walsh, Schenectady, N.Y. Address 1535 Myron St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Carcinoma DUE TO (c) Adeno carcinoma (Papillary) Jejunum					INTERVAL BETWEEN ONSET AND DEATH 24 hours 2 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from December 4, 1958 , to December 5, 1958 , that I last saw the deceased alive on December 5, 1958 , and that death occurred at 12:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC DATE SIGNED 12-6-58 ACTUAL SIGNATURE R. F. Mading M.D. PHYSICIAN'S NAME (Type) R. F. MADING, LT, MC, USN Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-9-58	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	22d. LOCATION (City, town, or county) (State) Arlington, Virginia				
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Thompson ADDRESS Bethesda, Md.			24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			
WHEELER & THOMPSON Funeral Dir. Fredericksburg, VA DATE DEC 9 '58							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13889

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Sant.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marian Tatham Walaity</u>		4. DATE OF DEATH Month Day Year <u>12-28-1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-6-18</u>
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>part time Holy Trinity Convent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Convent</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Samuel Tatham</u>		14. MOTHER'S MAIDEN NAME <u>Marie Connor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>Waves</u>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Left Breast with Cytotoxic Metastasis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 25, 1958</u> to <u>Dec. 28, 1958</u> , that I last saw the deceased alive on <u>Dec. 28, 1958</u> and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herman I. Slate</u> , M.D.		ADDRESS (Street, city or town, state) <u>3260 Wilson Blvd, Arlington, Va.</u>	
PHYSICIAN'S NAME (Type) <u>Herman I Slate</u>		DATE SIGNED <u>3260- Wilson Blvd Arlington, Va.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-31-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>	22d. LOCATION (City, town, or county) (State) <u>Switzland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.F. FUNERAL HOME 300 4th St NE</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>DEC 31 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Funn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

92251

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13890

CERTIFICATE OF DEATH

14047

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Sanit Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u> d. STREET ADDRESS <u>18105 Tabona Dr. SS, Md</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EULA</u> Middle <u>FAYE</u> Last <u>Watson</u>				4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>1958</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-15-03</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>15</u> Hours <u>15</u> Min. <u>58</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Tenn</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>Martha Shoun</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Benjamin V. Watson</u> Address <u>8105 Tabona Dr</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO <u>1 yr.</u> (c) <u>Hypertension</u> DUE TO <u>3 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SS7</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar. 3, 1956</u> to <u>Dec. 13, 1958</u> , that I last saw the deceased alive on <u>Dec. 13, 1958</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>3055-16th St. N.W., WASH, D.C.</u>			
PHYSICIAN'S NAME (Type) <u>IRWIN YAGER</u>				DATE SIGNED <u>Dec 15 58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		22b. DATE THEREOF <u>12/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Caldwell Springs Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elizabethton, Carter County, Tenn</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 18 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>							

CERTIFICATE OF DEATH

Form 10-1-10

1. Name of deceased (Print or write in full)

2. Date of death

3. Place of death (City, town, village, or hamlet)

4. County

5. Age at death (Years and months)

6. Sex

7. Race

8. Marital status

9. Occupation

10. Cause of death (Immediate)

11. Cause of death (Underlying)

12. Manner of death

13. Signature of physician

14. Signature of registrar

15. Date of registration

16. Place of registration

17. Name of registrar

18. Signature of registrar

19. Date of registration

20. Place of registration

21. Name of registrar

22. Signature of registrar

23. Date of registration

24. Place of registration

25. Name of registrar

26. Signature of registrar

27. Date of registration

28. Place of registration

29. Name of registrar

30. Signature of registrar

31. Date of registration

32. Place of registration

33. Name of registrar

34. Signature of registrar

35. Date of registration

36. Place of registration

37. Name of registrar

38. Signature of registrar

39. Date of registration

40. Place of registration

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14060

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>DINWIDDIE</u> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PETERSBURG</u> <u>83x-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11,218 MONTICELLO STREET</u> <u>CENTREHILL APTS.</u>			d. STREET ADDRESS <u>APT. #51</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>SUTILLA LOUISE WEBB</u>			4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>29</u> Year <u>19 58</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 22, 1904</u>		9. AGE (In years last birthday) <u>54</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>			13. FATHER'S NAME <u>WILLIAM HENRY HEATH</u>		
14. MOTHER'S MAIDEN NAME <u>CLEORA D. HOUSE</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>230-18-6419</u>			17. INFORMANT <u>ROBERT O. WEBB, PETERSBURG, VA.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x History of diabetes for several years</u>					INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHART</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>DEC. 29, 1958</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SOUTHLAWN MEM. PARK CEMETERY</u>	
22d. LOCATION (City, town, or county) <u>PETERSBURG, VA.</u>		22e. (State) <u>VA.</u>		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>			ADDRESS <u>SILVER SPRING, MD.</u>		
24a. REC'D BY REGISTRAR <u>DEC 31 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinard</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JAN 11 1914
BALTIMORE

1. Name of deceased		2. Sex		3. Age		4. Race		5. Occupation	
6. Date of death		7. Time of death		8. Place of death		9. Cause of death		10. Manner of death	
11. Signature of medical examiner		12. Signature of coroner		13. Signature of registrar		14. Signature of physician		15. Signature of undertaker	
16. Signature of witness		17. Signature of witness		18. Signature of witness		19. Signature of witness		20. Signature of witness	
21. Signature of witness		22. Signature of witness		23. Signature of witness		24. Signature of witness		25. Signature of witness	
26. Signature of witness		27. Signature of witness		28. Signature of witness		29. Signature of witness		30. Signature of witness	
31. Signature of witness		32. Signature of witness		33. Signature of witness		34. Signature of witness		35. Signature of witness	
36. Signature of witness		37. Signature of witness		38. Signature of witness		39. Signature of witness		40. Signature of witness	
41. Signature of witness		42. Signature of witness		43. Signature of witness		44. Signature of witness		45. Signature of witness	
46. Signature of witness		47. Signature of witness		48. Signature of witness		49. Signature of witness		50. Signature of witness	
51. Signature of witness		52. Signature of witness		53. Signature of witness		54. Signature of witness		55. Signature of witness	
56. Signature of witness		57. Signature of witness		58. Signature of witness		59. Signature of witness		60. Signature of witness	
61. Signature of witness		62. Signature of witness		63. Signature of witness		64. Signature of witness		65. Signature of witness	
66. Signature of witness		67. Signature of witness		68. Signature of witness		69. Signature of witness		70. Signature of witness	
71. Signature of witness		72. Signature of witness		73. Signature of witness		74. Signature of witness		75. Signature of witness	
76. Signature of witness		77. Signature of witness		78. Signature of witness		79. Signature of witness		80. Signature of witness	
81. Signature of witness		82. Signature of witness		83. Signature of witness		84. Signature of witness		85. Signature of witness	
86. Signature of witness		87. Signature of witness		88. Signature of witness		89. Signature of witness		90. Signature of witness	
91. Signature of witness		92. Signature of witness		93. Signature of witness		94. Signature of witness		95. Signature of witness	
96. Signature of witness		97. Signature of witness		98. Signature of witness		99. Signature of witness		100. Signature of witness	

CERTIFICATE OF DEATH

Reg. Dist. No.

215

14061

1. PLACE OF DEATH a. COUNTY Montgomery County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1 Month 16 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax ALEXANDRIA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria d. STREET ADDRESS 709 Ripley Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Edna Frances WELLS				4. DATE OF DEATH Month Day Year December 27 1958			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1915 28 September 1916	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) yrs. Months Days Hours Min. 43	
11. BIRTHPLACE (State or foreign country) Massachusetts				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John HANLON				14. MOTHER'S MAIDEN NAME Annie KERRIGAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 022-09-0832		17. INFORMANT Husband Edmund L. WELLS, LCDR USN	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) bronchopneumonia, right lower lobe DUE TO 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastatic adenocarcinoma of lung to brain DUE TO 4 months (c)				INTERVAL BETWEEN ONSET AND DEATH 6 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec. 14, 1958 , to Dec. 27, 1958 , that I last saw the deceased alive on Dec. 27, 1958 , and that death occurred at 2:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Matthew W. Wood MD				ADDRESS (Street, city or town, state) Bethesda Naval Hospital			
PHYSICIAN'S NAME (Type) MATTHEW W. WOOD LT MC USN				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL - SHIPMENT 12-29-58				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETARY				22d. LOCATION (City, town, or county) (State) WOBURN, MASSACHUSETTS			
23. FUNERAL DIRECTOR'S SIGNATURE Robert S. Muppy 3524 Columbia Pike				24a. REC'D BY REGISTRAR DEC 31 '58			
24b. REGISTRAR'S SIGNATURE Arthur L. Kneass				24c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16

Name of Deceased		Sex		Age	
Date of Birth		Place of Birth		Usual Residence	
Date of Death		Place of Death		Cause of Death	
Time of Death		Occupation		Manner of Death	
Physician		Funeral Home		Burial Place	
Signature of Registrar		Signature of Physician		Signature of Coroner	
Date of Registration		County		City	
State		Zip		Telephone	

CERTIFICATE OF DEATH

Reg. Dist. No.

14062

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo	
d. NAME OF HOSPITAL (If not in hospital, give street address) Suburban Hospital				d. STREET ADDRESS 14 Oberlin Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARIEL JENKINS		First Middle Last WIENER		4. DATE OF DEATH Month Dec. Day 22 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1888	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 5 Days 11	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Everard Fisher				14. MOTHER'S MAIDEN NAME Constantia Fisher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) No		16. SOCIAL SECURITY NO. 577-09-3634B		17. INFORMANT Gladys E. Kennedy-Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of lung DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 weeks 1 yr							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from April 1959 , 19____, to Dec 22 1958 , that I last saw the deceased alive on Dec 22 1958 , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE George Sharpe		M.D. 10511 Summit Ave		ADDRESS (Street, city or town, state) Keenington Md		DATE SIGNED 12/22/58	
PHYSICIAN'S NAME (Type) George Sharpe							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/26/58	22c. NAME OF CEMETERY OR CREMATORY Potomac Church Cem.	22d. LOCATION (City, town, or county) (State) Potomac, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE DEC 29 '58		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1. NAME OF DECEASED George James Smith		2. DATE OF DEATH Dec. 22, 1953	
3. SEX Male		4. AGE 68	
5. RACE White		6. OCCUPATION Retired	
7. MARITAL STATUS Married		8. PLACE OF BIRTH Maryland	
9. PLACE OF DEATH Home		10. CAUSE OF DEATH Heart Disease	
11. SIGNATURE OF DECEASED George James Smith		12. SIGNATURE OF WITNESS John Doe	
13. SIGNATURE OF PHYSICIAN Dr. John Doe		14. SIGNATURE OF CORONER John Doe	
15. SIGNATURE OF REGISTRAR John Doe		16. SIGNATURE OF CLERK John Doe	

1. NAME OF DECEASED
2. DATE OF DEATH
3. SEX
4. AGE
5. RACE
6. OCCUPATION
7. MARITAL STATUS
8. PLACE OF BIRTH
9. PLACE OF DEATH
10. CAUSE OF DEATH
11. SIGNATURE OF DECEASED
12. SIGNATURE OF WITNESS
13. SIGNATURE OF PHYSICIAN
14. SIGNATURE OF CORONER
15. SIGNATURE OF REGISTRAR
16. SIGNATURE OF CLERK

14063

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 20 HOURS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X GAITHERSBURG d. STREET ADDRESS Rt. #2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BERTHA BELLE WILLIS				4. DATE OF DEATH Month Day Year DECEMBER 31 19 58			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/7/06	
9. AGE (In years lost birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME WILLIAM R. COOK				14. MOTHER'S MAIDEN NAME ROSE CROUSE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. NONE		17. INFORMANT HOSPITAL RECORDS Address OLNEY, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Carcinoma of recto-Sigmoid Colon DUE TO (c) Colon Cancer						INTERVAL BETWEEN ONSET AND DEATH? Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 28 , 19 58 , to Dec. 31 , 19 58 , that I last saw the deceased alive on Dec. 31 , 19 58 , and that death occurred at 9:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Jack Schumacher M.D.				PHYSICIAN'S NAME (Type) J. SCHUMACHER, M. D. GAITHERSBURG, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-2-59		22c. NAME OF CEMETERY OR CREMATORY Laytonsville Meth.		22d. LOCATION (City, town, or county) (State) Laytonsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber ADDRESS Laytonsville, Md.				24a. REC'D BY REGISTRAR DATE JAN 5 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

TIME OF DEATH

CAUSE OF DEATH

PLACE OF BURIAL

NAME OF DECEASED

DATE OF BURIAL

NAME OF FUNERAL HOME

NAME OF WITNESS

14064

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Spencerville</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Three Springs, MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARYLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spencerville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mildred</u> Middle <u>Leona</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>December</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/22/26</u>
9. AGE (In years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>17</u> Hours <u>17</u> Min. <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles F. Elliott</u>		14. MOTHER'S MAIDEN NAME <u>Ada F. Elliott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr Charles F Elliott</u>	
17. INFORMANT <u>Mr Charles F Elliott</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Obstruction of Ureter (lost)</u> DUE TO (c) <u>Metastasis from Carcinoma of Cervix</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7+ days</u> <u>4 1/2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Right Nephrectomy Jan. 28, 1958</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 3, 1957</u> to <u>Dec. 16, 1958</u> , that I last saw the deceased alive on <u>Dec. 13, 1958</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. P. McNeill</u>		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave</u>	
PHYSICIAN'S NAME (Type) <u>W. P. McNeill, M.D.</u>		DATE SIGNED <u>Dec. 16, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/18/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>		22d. LOCATION (City, town, or county) (State) <u>Spencerville Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Sawoodson, Funeral Home</u>		ADDRESS <u>Spencerville Ind</u>	
24a. REC'D BY REGISTRAR <u>DEC 22 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14053

14065

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMORELAND HILLS</u>				c. LENGTH OF STAY IN 1b <u>19 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMORELAND HILLS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5225 ELLIOTT ROAD</u>				d. STREET ADDRESS <u>5225 ELLIOTT ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>W.</u> Last <u>WOOLNOUGH</u>				4. DATE OF DEATH Month <u>12</u> Day <u>3</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 21st.</u>	
9. AGE (In years lost birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T.</u>		11. BIRTHPLACE (State or foreign country) <u>MASS.</u>	
13. FATHER'S NAME <u>WILLIAM WOOLNOUGH</u> <u>XXXXXXXXXXXXXX</u>				14. MOTHER'S MAIDEN NAME <u>JESSIE FORREST</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Address <u>MARIE F. WOOLNOUGH-- SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>421.0</u> IMMEDIATE CAUSE (a) <u>acute dilatation of heart</u> DUE TO (b) <u>myocardial insufficiency</u> DUE TO (c) <u>generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 year</u> <u>1 year</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>58</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>Jan 20</u> , 19 <u>58</u> , to <u>Dec 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 3</u> , 19 <u>58</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. P.M. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>John R Dull</u> M.D. <u>907 E. Capitol St. Washington D.C.</u> PHYSICIAN'S NAME (Type) <u>JOHN R. DULL</u> <u>907 EAST CAPITOL STREET WASH. D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-8-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ALBANY RURAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WATERTOWN, N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> ADDRESS <u>Wash. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14066

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14054

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>NY</u> b. COUNTY <u>Syracuse</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elm</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Syracuse</u>	
c. LENGTH OF STAY IN 1b <u>8 mo</u>		d. STREET ADDRESS <u>Brooke Grove Foundation</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brooke Grove Foundation</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Redington Wright</u>		4. DATE OF DEATH <u>12-4-58</u>	
5. SEX <u>male</u>		6. DATE OF BIRTH <u>32-10-1876</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>82</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		11. BIRTHPLACE (State or foreign country) <u>NY</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Wright</u>		14. MOTHER'S MAIDEN NAME <u>Susan Short</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>902.7</u>	
17. INFORMANT <u>Hosp. Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO (b) <u>Carcinoma of prostate with metastasis</u> DUE TO (c) <u>months</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fell from chair against radiator 11-30-58 - 1st degree burn of face</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>902.7</u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>12-5-58</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Massena, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Julius Funeral Home - Catskill, N.Y.</u>		ADDRESS <u>Catskill, N.Y.</u>	
24a. REC'D BY REGISTRAR <u>DEC 8 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

14067

CERTIFICATE OF DEATH

14055

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Alta Vista Rest Home				e. STREET ADDRESS 5420 5520 Roosevelt Street			
3. NAME OF DECEASED (Type or print) First Thomas Middle Hicks Last Wright				4. DATE OF DEATH Month December Day 16 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1881	9. AGE (In years last birthday) 67 11 yrs.	IF UNDER 1 YEAR Months 3 Days 13 Hours Min. 		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General manager		10b. KIND OF BUSINESS OR INDUSTRY Haberdashery		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John N. Wright				14. MOTHER'S MAIDEN NAME Fannie Harrison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-05-6461		17. INFORMANT Louis Lewis Siegel-son-in-law-same as 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal hypertension (c) Diabetes Mellitus						INTERVAL BETWEEN ONSET AND DEATH 1 HR 10 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 48 , to Feb , 19 58 , that I last saw the deceased alive on Dec 15 , 19 58 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda 14 Maryland DATE SIGNED 12/17/58							
ACTUAL SIGNATURE Leo I Donovan				M.D. So 16			
PHYSICIAN'S NAME (Type) Leo I Donovan							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/19/58		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				24a. REC'D BY REGISTRAR DATE DEC 19 58		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

Reg. No. 114

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		JAN 15 1892		BALTIMORE, MARYLAND	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
JAN 15 1942		BALTIMORE, MARYLAND		HEART DISEASE	
TIME OF DEATH		HOURS		MINUTES	
10:00 AM		10		00	
SEX		AGE		MARRIED	
MALE		50		YES	
OCCUPATION		EDUCATION		RELIGION	
FARMER		8 YEARS		METHODIST	
PREVIOUS ILLNESS		DATE OF ONSET		DATE OF DEATH	
NONE		JAN 10 1942		JAN 15 1942	
ATTENDING PHYSICIAN		DATE OF EXAMINATION		PLACE OF EXAMINATION	
DR. J. H. HARRIS		JAN 15 1942		BALTIMORE, MARYLAND	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE		PLACE OF SIGNATURE	
J. H. HARRIS		JAN 15 1942		BALTIMORE, MARYLAND	
SIGNATURE OF REGISTRAR		DATE OF SIGNATURE		PLACE OF SIGNATURE	
J. H. HARRIS		JAN 15 1942		BALTIMORE, MARYLAND	

OFFICE OF THE REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14056

13891

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, 1615.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>		d. STREET ADDRESS <u>834 Bershire Drive,</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Yarmark</u>		4. DATE OF DEATH Month Day Year <u>December 11, 19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>137PM Dec. 11, 1958</u>
9. AGE (In years last birthday) yrs. <u>8</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Yarmark</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Ronald Wesley Yarmark</u>		14. MOTHER'S MAIDEN NAME <u>Norma Louise Oats</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>father</u>	
17. INFORMANT <u>father</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>atalectasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Immaturity (24 weeks)</u> DUE TO (c) <u>Premature separation of placenta</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 11, 1958</u> , to <u>Dec. 11, 1958</u> , that I last saw the deceased alive on <u>Dec. 11, 1958</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Herbert J. Friedel</u>		M.D. <u>6826 Riggs Rd., Hyattsville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Herbert J. Friedel, M. D. 6826 Riggs Rd., Hyatts., Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12-11-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hospital Takoma Park, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M. D. Washington Sanitarium and</u>		24a. REC'D BY REGISTRAR <u>Hospital Takoma Park, Md.</u>	
24b. REGISTRAR'S SIGNATURE <u>DEC 18 58</u>			

2075221XV0

Arthur L. Hare

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

14068

14057

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 12 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8303 Colesville Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE SHEPHERD YOUNG		4. DATE OF DEATH DEC. 11, 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/26/80
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet maker (retired)		10b. KIND OF BUSINESS OR INDUSTRY Smithsonian Institute	
11. BIRTHPLACE (State or foreign country) SCOTLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LIVINGSTON YOUNG		14. MOTHER'S MAIDEN NAME ISABELLA SHEPHERD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579-05-7523-B	
17. INFORMANT Mrs. Mary Ann Young, 8303 Colesville Rd., Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO (c) 5 years INTERVAL BETWEEN ONSET AND DEATH 30 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1949 to Dec. 11, 1958 , that I last saw the deceased alive on Dec. 8, 1958 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. B. Wardrop		ADDRESS (Street, city or town, state) 837 Bonfant St. Silver Spring, Md.	
PHYSICIAN'S NAME (Type) W. B. WARDROP		DATE SIGNED 12/15/58	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/15/58	
22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CATH. CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WERNER E. PUMPHREY, INC. Raymond A. Jaska		24a. REC'D BY REGISTRAR DEC 15 '58	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

